REQUEST FOR ADMINISTRATION OF MEDICATION

If this form is properly completed and returned to the school principal, the Carroll County School System may assist parents when their child's doctor has prescribed medicine that needs to be given during the school day. The medicine will only be given if it is delivered to the office in the original bottle marked with the student's name, dosage, name of medication, time to be given, physician, pharmacy, purchase date.

PARENTS: Complete this part for either short or long-term medicines

Name of Student: _____ Date: _____

Homeroom Teacher: _____

Name of Medicine: _____ Dosage: _____

Dates to be given: _____ Times to be given: _____

Doctor's Name: _____ Doctor's Phone: _____

Child's Allergies: _____ Prescription Date: _____

As parent/guardian of the above named student, I request that the school give this medicine to this student. I realize that school personnel will administer the medicine. While the school recognized the desirability of responding to the physician's request, this accommodation on the part of the school is not legally required. Therefore, I agree to hold the school and its personnel free from any or all suits that might arise from these arrangements. This contract is effect for one school year only or until the medicine or dosage is changed, whichever occurs first. I agree to replace this form each time my child's medicine or dosage is changed.

Signature of Parent/Guardian: _____ Date: _____

Signature of Principal/Designee: _____ Date: _____

Person assigned to give the medication: _____

PHYSICIAN: Complete for medication to be given more than 30 days.

Illness requiring above medication: _____

Possible side effect I want to be notified about: _____

Student is capable of self-administering:

Asthma inhaler	_____	Yes	_____	No	_____	N/A
Epipen	_____	Yes	_____	No	_____	N/A
Insulin	_____	Yes	_____	No	_____	N/A

Physician's Signature: _____ Date: _____

Print Name: _____ Phone: _____