HENDERSON COUNTY PUBLIC SCHOOLS
STUDENT SUPPORT SERVICES
REV 8/02

Request for Medication Administration

Student's Name_____ **School**_____
I hereby request that my child receive medication during school hours. I hereby release the School Board and their agents and employees from all liability that may result from my child taking the prescribed medication.

_____ _____ _____
Parent or Guardian's Signature Phone Number Date

Medication_____ Dosage_____

Time(s) medication is to be given: a.m._____ p.m._____ To be given from (date)_____ to_____

Significant Information (including side effects, toxic reactions, omission reactions):_____

Contraindications for Administration:_____

If emergency situation occurs during the school day or if the student becomes ill, school officials are to:

a. Contact physician_____ Phone_____
b. Take child immediately to the emergency room at _____
c. Other option_____

This medication will be furnished by parent or guardian in a container properly labeled by a pharmacist with identifying information (e.g., name of the child, medication dispensed, dosage prescribed, and expiration date).

Check if child self-medicates*_____(Insulin, inhalers, epipen). <u>If checked, this child has been properly trained to self medicate by this office.</u>
*The school will not be responsible for students who self-medicate.

_____ Physician's signature Date_____

(SCHOOL USE ONLY)

Name and title of person to administer medication (1)_____
(2)_____ (3)_____ (4)_____

Approved by _____ _____
Principal's Signature Date

Reviewed by_____ _____
School Nurse's Signature Date