RANDOLPH County School System

Request For Medication To Be Given During School Hours and/or School Sponsored Activities

TO BE COMPLETED BY PHYSICIAN

Please complete one form for each medicine to be administered

Name of Student: _____ DOB:_____

Teacher (Grade): _____ School: _____

Medication: _____ **Dosage**: _____

Date Range for to administered medicine: _____to _____

Time of Day to administer medicine: _____

Significant Information (include side effects, toxic reactions, and omission reactions):

Contraindications for Administration:

Physician's Signature: _____ Date: _____

Office Address: _____Phone: _____

This medication must be furnished by a parent/guardian within a container properly labeled by a pharmacist with identifying information (e.g. Name of child, medication dispensed, dosage prescribed, and the time it is to be given).

TO BE COMPLETED BY PARENT/GUARDIAN

If an emergency situation occurs during the school day, school officials are to: (check all that apply)

- ☐ Contact/call me at _____.
- ☐ Take my child immediately to the emergency department at _____.
- ☐ Other: _____.

I hereby give my permission for my child (named above) to receive medication during school hours and/or school sponsored activities. This medication has been prescribed by a licensed physician. 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/Guardian Signature:_____ Date: _____

Contact Number: _____

School Use Only:

Name and title of person to administer medication: _____

Reviewed by: _____

School Nurse Signature Date