# Administration of Medication at School

Please have your health care provider complete this form for all prescription or non-prescription medications he/she prescribes.

Student _____ Grade _____

Birth date_____ School ____St. Francis Solano School_____

Medication(s) _____

Dosage, time, and method of administration_____

_____

Physical condition for which drug is to be given. If allergic in nature, please specify what type of reaction, i.e., localized, generalized, mild, severe _____

_____

Possible reactions that need to be reported to the care provider _____

_____

Disposition of student following administration of medication, i.e., rest, home, hospital, doctor's office, return to class, notification requests_____

_____

The above medication cannot be scheduled for other than during school hours, and such medication may be administered by medically untrained school personnel whenever necessary.

Health care provider's name _____

Phone_____ Address _____

Date of Request_____ Medication to be continued until (date) _____

Health care provider's signature _____ Date_____

I request that my child (the above named student) be assisted taking the above medication at school by school personnel, and will comply with the policy and procedures of the school as outlined in the letter on the reverse side. I give my consent for the school administrative team (principal, secretary, bookkeeper) to communicate with the physician/health care provider and to counsel with school personnel regarding the above named student and medication as appropriate. I understand the school is not legally obligated to administer medication to any student and therefore agree to hold the school harmless from any liability resulting from the administration of above named medication(s).

Parent signature_____ Date _____