THE PLACE TO BE

ADMINISTERING MEDICINES TO STUDENTS
AUTHORIZATION FOR DISPENCING PRESCRIPTION MEDICATION

JHCD 1-E

Note: Whenever possible, medication should be given at home and every effort should be made to avoid school hours.

To Be Completed By Parent or Guardian:

I request that my child, _____, date of birth, _____, grade, _____, receive the medication as prescribed by our physician in the form below. The medication is to be furnished by me as required by Board policy. I understand that the District does not assume any responsibility for this matter. I further understand that the school nurse or other designated person will administer the medication. I agree to submit a revised statement signed by the physician if the previously provided information changes.

Signature (Parent or Guardian) _____

Phone Number (Home) _____ (Work)_____

Address _____

School _____ Homeroom Teacher_____

Date _____ _____

To Be Completed By Physician:

I request that my patient receive the following medication:

Name of student _____ Diagnosis _____

Name of medication _____

Prescribed dosage and means of administration _____

Time to be taken during school hours _____

Date the administration of drug is to begin _____ Expected duration of treatment _____

Possible side effects and adverse reactions _____

Any special instructions for the administration of the drug, including sterile conditions and storage

_____

_____

Physician Signature_____ Phone Number _____ Date _____