REQUEST FOR PRESCRIPTIONS
and/or
LONG-TERM MEDICATIONS AT SCHOOL

STUDENT: ____

MEDICATION: ____

REASON FOR MEDICATION: ________________________________

MEDICATION TO BE TAKEN FROM ____________ **TO** ____________

DOSE ____________ **TIME** ____________ **HOW OFTEN** ____________

POSSIBBLE SIDE EFFECTS **ACTION TO BE TAKEN**

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Doctor's Signature: ________________________

Date: ________________________

IT IS UNDERSTOOD THAT THE SCHOOL SYSTEM IS NOT BOUND TO HONOR THIS REQUEST. IN CONSIDERATION OF THE SCHOOL'S ACCEPTANCE OF THIS REQUEST, THE UNDERSIGNED RELEASES AND SAVES HARMLESS IT'S SCHOOL BOARD, IT'S BOARD AGENTS, AND EMPLOYEES FORM ALL CLAIMS THAT MAY ARISE AS A RESULT OF ACTION OR INACTION RESULTING FROM THE REQUEST HEREIN MADE. IT IS UNDERSTOOD THAT THE PARENTS OR GUARDIANS ACCEPT FULL RESPONSIBILITY FOR THIS ADMINISTRATION OF MEDICATION AT SCHOOL.

Signature of Parent or Guardian: ________________________________

Date: ________________ **Phone No. During School Day:** ____________________