Franklin County Schools
School Health Services
Request for Medication to Be Given During School Hours

To be completed by physician

Name of Student ______________________________________ School ____________________________

Medication ____ Dosage ___________________________
(No injection will be given except on extreme emergency, such as allergy to wasp or bee sting.)

Time(s) medication is to be given: am ____ pm ____ to be given from (date) ___________ to __________

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

____

Contraindications for Administration; ____

____

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

a. Contact me at my office ___________________________________Phone ___________________

b. Take child immediately to the emergency room at _______________________________________

c. Other option ____

This medication will be furnished by parent or 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).

____ DEA# _________________________ Date ___________
Physician's Signature

PARENT'S PERMISSION

I hereby give my permission for my child (named above) to receive medication during school hours. 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's Signature Phone # Date

(School Use Only)

Name and title of person to administer medication ____

Approved by ____ _______________
Principal's Signature Date

Reviewed by ____ ______________
School Nurse's Signature Date