PARK COUNTY SCHOOL DISTRICT #6
BOARD OF EDUCATION POLICY

REQUEST FOR ADMINISTRATION OF MEDICATION
PRESCRIPTION ONLY

Med Form 1

Student's Name:_____ Date of Birth:_____

School:_____ Grade:_____

TO BE COMPLETED BY PHYSICIAN:

Diagnosis:_____

Rx (Dosage/Frequency/Route):_____

Reportable Adverse Reactions/Side Effects:_____

_____

Beginning Date:_____ Ending Date:_____

List Other Medications Currently Being Taken:_____

_____

Name of Prescribing Physician:_____ Date:_____
Please Print

Physician's Signature:_____

The medication must be in its original manufacturer's container, box or bottle stating the name of the student and dosage.

I request that the Principal or his/her designee administer the medication as directed above. I understand that it is my child's responsibility to report to the office for this service. I authorize the release of information between the school and physician pertinent to my child's medication.

_____ _____ _____ _____
Parent/Guardian Signature Date Phone # Emergency #

INHALER/EPI-PEN EXCEPTION:
My child has been instructed in the proper use of the above medication. I request that he/she be permitted to carry and self-administer the medication. PCSD #6 will assume no responsibility or liability for the self-medication by a student or for the medication carried by the student.

_____ _____
Parent/Guardian Signature Date