SANBORN REGIONAL SCHOOL DISTRICT

PHYSICIAN'S REQUEST FOR ADMINISTRATION OF PRESCRIPTION MEDICATION

Name of Student ___________________________________Age________Grade __________

Address ____

PHYSICIAN'S ORDERS:

Diagnosis ____

Medication ____

Dosage _______________________Route__________________Time ____________________

Duration ________________Prescription #___________Pharmacy _______________________

Possible side effects (if any) ____

Other meds student is taking/Remarks____

Date ______________ ____.
Physician's/Prescriber's Signature

Phone #______________ Printed Name____

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PARENTAL PERMISSION/HOLD HARMLESS STATEMENT

I, the parent/guardian, authorize the school administrator to direct members of the school staff to assist my child in taking the above medication and agree that I will not hold liable, any member of the school staff or an individual of official capacity who is directed by me (parent/guardian) and the school administrator to assist my child in taking said medication.

____ ____________________
Parent/Guardian Signature Date

Printed Name_______________________________________

Note: If there are any questions or concerns, please call the school nurse.

Original: March 5, 2008