

WAYNE COUNTY SCHOOLS
REQUEST FOR MEDICATION AT SCHOOL
(Prescription and Non-prescription)

Student's Name _____ School _____

Birth date _____ Grade _____ Parent's name _____

TO BE COMPLETED BY PHYSICIAN:

Date of order _____

Name of medication _____ Dosage _____

Route of administration _____ Frequency of administration _____

Diagnosis _____

Intended effect of medication _____ Discontinuation Date _____

Other medication student is receiving _____

Time interval for reevaluation _____

Possible adverse effects of this medication _____

Lay person may be trained to administer this medication _____

Doctor's SIGNATURE _____

Telephone # _____ Address _____

TO PARENT/GUARDIAN:

Medication must be brought to school in a container appropriately labeled by the pharmacy or physician; nonprescription medications ordered by a physician should be brought with the original label and the student's name affixed to the container. Only those medications which are necessary to maintain the student in school or must be given during school hours shall be administered. If you have any questions, please call the school nurse.

The school district and its employees and agents are to incur no liability, except for willful and wanton misconduct, as a result of any injury arising from the self-administration of medication by the pupil.

I hereby authorize the above named school and its certified employees to act in my behalf to supervise the administration to by student (or supervise self-administration) the medication prescribed above. I acknowledge that a school nurse may not be available to supervise the administration and specifically consent to certificated school employees giving the medication instead of the school nurse.

Date _____

(Signature of parent/guardian)

Phone _____

Emergency/work phone # _____