Medication Agreement to Dispense Medication in School

Please return to _____ Fax _____
School

Name: _____ **DOB** _____ **ID#** _____

School: _____ **Grade / Teacher** _____

Medication _____

Dose _____ Route _____

Frequency _____

Medication used for _____

Possible Side Effects _____

This order in effect for the period from _____ to _____
Month / Day / Year Month / Day / Year

Printed Name of Prescribing Practitioner _____

Prescribing Practitioner Signature _____ **Date** _____

It is agreed and understood that this medication will be provided by the parent / guardian in the original bottle, labeled with the name of the medication, dosage, route of administration, frequency of use and clearly marked with the student's name.

It will be kept locked in the health office and dispensed by the school nurse or trained school designee as per the orders noted above.

By authorizing the giving or administration of the medication, the parent(s)/guardian(s) of the above child will release and hold harmless PSD, the school nurse or trained school designee of any claim, demand or action associated with the administration or failure to administer the medication.

☐ By checking this box: I give permission for the school health office staff to contact the prescribing health care provider regarding this medication and / or health condition.

Parent / Guardian Signature _____ **Date** _____