REQUEST FOR MEDICATION TO BE ADMINISTERED AT SCHOOL

I request that (child's name):_____ DOB: _____ Grade: _____
be allowed to take the following medication at school:

ALL MEDICATION MUST BE IN ITS ORIGINAL LABELED CONTAINER.

☐ Prescription ☐ Over-the-Counter

Name of Medication: _____

Reason for Medication: _____

Dosage to be given: _____

Frequency/Time to be given: _____

Physician's Name (print): _____

Physician Signature (for prescription medications): _____

I hereby give my permission for the above medication to be administered by the school nurse or other designated school personnel in the nurse's absence. By signing below, I verify that I have administered at least one dose of the above medication to my child without adverse effects. I request that my child receive this medication according to the written prescription provided; all OTC medications will be administered in accordance with the manufacturer's label unless otherwise prescribed.

I understand this information is confidential according to the Family Rights and Privacy Act (FERPA), and school personnel will have access to this information on a need-to-know basis. I agree to coordinate and work with school personnel and prescriber if questions arise.

Parent/Guardian Signature: _____

Phone number: _____

Date: _____

- NOTE: Per Steelville R-3 School District's "Administration of Medications to Student's" policy, both prescription and over-the-counter medications shall be prescribed by the student's physician in order to be administered throughout the school day. **ALL MEDICATIONS MUST BE BROUGHT IN TO THE SCHOOL NURSE BY A PARENT/GUARDIAN AND WILL BE DESTROYED OR DISCARDED IF NOT PICKED UP WITHIN ONE WEEK BEYOND THE CLOSE OF SCHOOL.**

Date received by school nurse: _____

Date picked up by parent: _____