

Anderson School District One School Health Services



PRESCRIPTION MEDICATION

Dear Principal:

I request that a member of the school staff assist my child _____ with medication, according to doctor's order. I understand that the principal or his/her designee may assist with the medication. I had my child's physician complete the required statement, naming the medication, the dosage, and the time the medication should be taken. I understand that it will be my child's responsibility to remind school officials of the time the medication is to be taken. I am aware that school employees are not licensed to administer injections or medications and have no special training in such procedures. I hereby agree not to hold the school district or school personnel liable for any adverse drug reactions when the medication is taken according to prescribed method. I understand that the school district/principal may deny this request for legitimate reasons.

Parent

Signature: _____

Date _____

Doctor's Statement

Patient's Name: _____ Date of Birth: _____

My patient needs to take the following:

<u>Medication</u>	<u>Dosage and Time</u>	<u>Adverse Reactions</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Diagnosis Code: _____

Date medication to begin: _____

Date medication to end: _____

It is district policy that the medication must be brought to the health room in the original labeled bottle or package.

It is necessary for this child to take this medication while attending school:

Physician's Signature: _____ Date: _____

Telephone Number: _____

Fax Number: _____