GERMANTOWN SCHOOL DISTRICT
PARENTAL REQUEST FOR
ADMINISTRATION OF PRESCRIBED MEDICATION
(Physician Signature Required)

Date: _____ School: _____

_____ is in need of medication during school. I hereby give permission to school staff designated by the principal to administer the below listed medication (one medication per sheet). It is my understanding that medication will be administered under the general supervision of a district designated health care professional.

Parent/Guardian Initials _____

Name of Medication: _____ Reason for Medication: _____

Dosage: _____ Time of Administration: _____

How to be Given (i.e. with water, with food): _____

Physician: _____ Clinic: _____Phone: _____

I also give permission for the school staff, including the district designated health care professional, to contact my child's physician with any concerns regarding medication administration.

Parent/Guardian Initials _____

I also give the school staff, including the district designated health care professional, permission to call me with any concerns regarding medication administration.
Home Phone: _____ Work Phone: _____

Parent/Guardian Initials _____

I will notify the school in writing at the termination of request for medication administration, or of any change in directions of administration. In the event that I revoke consent for medication administration or discontinuance due to physician orders, I understand that a new Parental Request for Administration of Medications would need to be completed and signed by physician to reinitiate this request.

Parent/Guardian Initials _____

I agree to supply the school with no more than a 4 week supply of medication. (Medication is to be delivered to the school office by parent or parent designated adult only)

Parent/Guardian Initials _____

Prescription medication will be supplied in a pharmacy labeled container. The label will have the child's name, drug name, dosage, and how often to be taken. Also, the name of the prescribing physician will be on the label, along with the pharmacy name and phone number.

Parent/Guardian Initials _____

I understand that I cannot send prescription medications to school with my child. The parent, or a responsible adult designated by parent, is expected to deliver any necessary medications to their child's school. An exception to this rule might be made only if the parent has requested approval for student self-administration of medication and the request has been approved by the building principal.

Parent/Guardian Initials _____

I understand that no medication will be administered by the school without full compliance of the above stated terms and conditions. **(Physician signature is required for all prescribed medication)**

_____ _____

Parent Guardian Signature **Date**

_____ _____

Physician Signature **Date**