ROMEO COMMUNITY SCHOOLS

REQUEST FOR ADMINISTRATION OF MEDICATION TO STUDENT

Powell Middle School Telephone: 586-752-0270 Fax: 586-752-0276

PARENT

Under certain conditions, as a service to you and for the welfare of your child, school personnel may agree to honor parent requests for the administration of necessary medication to students.

PLEASE BE SURE THE FOLLOWING STEPS HAVE BEEN TAKEN:

*Medication(s) must be in original container and clearly labeled.

*Medication must be brought to school by an adult

*Prescription medication must indicate: (1) student's name (b) dosage (c)doctor's name , (d) pharmacy name (e) date issued (f) prescription number

The written statement below, signed and dated by the attending physician, supporting this parental request is required. The physician's statement must provide clear directions for administering the medication in school.

1. I do hereby request and authorize medication to be given to my (son/daughter), and I give permission for staff to contact my child's doctor regarding administration and effects of the medication ordered.
2. I will assume responsibility for safe delivery of the medication to school by myself or an adult.
3. I will notify the school immediately if there is any change in the use of the medication of the prescribed treatment.
4. I will release and agree to hold the Board of Education, its officials, its employees, and its third party contracted individuals harmless from any and all liability, foreseeable and unforeseeable, for damages or injury resulting directly or indirectly from this authorization.

Student Name: _____ ***School:*** _____

Address: _____

(Street Name) (City) (State) (Zip)

Grade: _____ ***Home Phone:*** _____ ***Cell Phone:*** _____

Parent/Guardian Signature: _____ ***Date:*** _____

PLEASE NOTE THAT SCHOOL STAFF ARE ADMINISTERING MEDICATIONS.
ALL LANGUAGE/DIRECTIONS MUST BE IN LAY TERMS.

PHYSICIAN

I recommend that medication be given to _____ in school.

*Medication Name: _____

*Total Dosage: _____mg., _____ puffs, _____ other: _____

*Times to Administer: _____Lunch _____Other time _____As Needed (Specify symptoms or circumstances when medication is to be given.): _____

*Frequency: _____

*Purpose of medication: _____

*Possible side effects: _____

Physician's Signature: _____ **Date:** _____

Physician's Name: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Telephone: ( ) _____ Fax: ( ) _____