**EAGLE MOUNTAIN – SAGINAW ISD**
**REQUEST FOR ADMINISTRATION OF PRESCRIPTION MEDICATION AT SCHOOL**

Medication should be given outside of school hours if at all possible. If it is necessary for the student to have medication at school, parent/guardian and physician MUST complete this form. **MEDICATION MUST BE BROUGHT IN THE ORIGINAL CONTAINER WITH THE PROPER LABELING INSTRUCTIONS.** Recommended dosage or frequency of administration will not be exceeded without verification from physician. Medication will be kept locked in the nurse's office. Students may NOT carry or self administer medications at school unless determined to be a medical necessity by the physician and a written statement from the doctor is on file in the Health Service's office.

At the end of the school year, unused medication will be discarded unless picked up by the parent/guardian.

NAME OF
STUDENT______________________________________DATE____________________

TEACHER
NAME__________________________________________GRADE___________________

| MEDICATION | STRENGTH | DOSAGE | TIME(S) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

COMMENTS:
______________________________________________________________________

______________________________________________________________________

PHYSICIAN'S NAME________________________________PHONE # _____________________

PHYSICIAN'S SIGNATURE ________________________________ DATE __________________

I hereby request that the medication listed above be administered to my child during school hours. I hereby release the school from liability due to allergic reaction.

______________________________________ ______________________
PARENT/GUARDIAN SIGNATURE DATE

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*IF MY CHILD FORGETS TO TAKE A MORNING DOSE AT HOME, YOU HAVE MY PERMISSION TO ADMINISTER THAT DOSE AT SCHOOL AFTER CALLING ME TO VERIFY THE MISSED DOSE.*

______________________________________ ______________________
*PARENT/GUARDIAN SIGNATURE* *DATE*

*This form may be duplicated or additional forms may be obtained from the school.* *1/04*