# SANBORN REGIONAL SCHOOL DISTRICT

SRSD File: JLCD-R1

## PHYSICIAN'S REQUEST FOR ADMINISTRATION OF PRESCRIPTION MEDICATION

Name of Student _________________________________Age_______Grade _________

Address _______________________________________________________________

PHYSICIAN'S ORDERS:

Diagnosis ______________________________________________________________

Medication _____________________________________________________________

Dosage _____________________Route________________Time __________________

Duration _______________Prescription #__________Pharmacy ______________________

Possible side effects (if any)

___________________________________________________

Other meds student is taking/Remarks_____________________________________________

Date _____________        ______________________________________________.

Physician's/Prescriber's Signature

Phone #_____________ Printed Name__________________________________________

* * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * *

PARENTAL PERMISSION/HOLD HARMLESS STATEMENT

I, the parent/guardian, authorize the school administrator to direct members of the school staff to assist my child in taking the above medication and agree that I will not hold liable, any member of the school staff or an individual of official capacity who is directed by me (parent/guardian) and the school administrator to assist my child in taking said medication.

_______________________________________          ___________________

Parent/Guardian Signature                                        Date

Printed Name___________________________________

Note: If there are any questions or concerns, please call the school nurse.

History:

Original: March 5, 2008
Renewed: January 23, 2019