Abilene USD #435
Request to Administer Medication at School

Student:____

School:__________________________ Grade:_________________

Teacher:____

Medication:______________________________ Dosage:______________________

Date Started:__________________________ Reason: ________________________

Time of day medication to be given:____

Anticipated number of days to be administered at school: ________________________

Physician Signature:_________________________________ Date:_____________

ASTHMA / DIABETIC / EPI-PEN STUDENTS ONLY:

This student is both capable and responsible for self-administering:
___No ___Yes- supervised ___Yes-unsupervised
This student may carry his/her own insulin / inhaler / epi-pen:
___No___Yes

I hereby give my permission for __________________________________ to take the above medication at school as ordered. I understand that it is my responsibility to furnish this medication. I further understand that any school employee who administers any drug to my student in accordance with written instructions from the physician/dentist shall not be liable for damages as a result of an adverse drug reaction suffered by the student. This student has had at least one dose of the medication and did not have an adverse drug reaction.

Date:___________________ ____________________________________
Signature of parent/guardian

****Note: **ALL** prescriptions **MUST** be brought to school in the original container and properly labeled from pharmacy. Over the counter medications **MUST** be in the original container with student's name written on the package. If the medication does not have this signed form, and/or is not in the original container from the store or pharmacy --**IT CANNOT BE GIVEN**. ****

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School Nurse