MILLVILLE AREA SCHOOL DISTRICT
MILLVILLE, PENNSYLVANIA

REQUEST FORM TO ADMINISTER MEDICATION

(TO BE COMPLETED BY PHYSICIAN)

_____ must receive the following medication in order to maintain sufficient health to participate in the school program.

NAME OF MEDICATION: _____

DIAGNOSIS WHEN NEEDED: _____

DOSAGE TO BE ADMINISTERED: _____

TIME TO BE ADMINISTERED: _____

LENGTH OF TIME MEDICATION IS TO BE GIVEN:

FROM _____ TO _____
(DATE) (DATE)

FOR INHALED MEDICATIONS:

- □ This student has been instructed in the proper way to use his/her medications. It is my professional opinion that he/she should be allowed to carry and use that medication by him/herself.
- □ It is my opinion that this student should not carry his/her inhaled medication by him/herself.

PHYSICIAN NAME:_____PHONE #: _____

SIGNATURE OF ATTENDING PHYSICIAN: _____

COMMENTS BY PHYSICIAN: _____

_____

(TO BE COMPLETED BY PARENT/GUARDIAN)

I, therefore, request the school district personnel to give my child the above medication.

I do hereby release, discharge and hold harmless the school district and its agents and employees, from any and all liability and claim whatsoever for the administration of the above medication to my child should there develop a reaction from the medication, and/or ensuring that self-administered medication is taken.

PRESCRIPTION NUMBER: _____

DATE ON BOTTLE: _____

SIGNATURE OF PARENT/GUARDIAN: _____

DATE: _____