GREENE COUNTY CAREER CENTER

RELEASE AND REQUEST FOR THE ADMINISTRATION OF MEDICATION AT SCHOOL

PART I—TO BE COMPLETED BY PHYSICIAN

Name of Student _____

Address of Student _____

Name of medication to be administered _____

Dosage _____ Route _____ Time(s) _____ [ ] daily [ ] prn [ ] other

Date to begin _____ Date order expires _____

Special instructions (administration, storage, indications, etc.) _____

_____

Possible side effects or reactions that might occur and should be reported to physician: _____

_____

Physician's name (please print) _____

Physician's address _____

Physician's phone number _____ **Emergency phone number** _____

Signature of Physician _____ **Date** _____

PART II—TO BE COMPLETED BY PARENT OR GUARDIAN

We (I) understand that the administration of said medication is to be done under the supervision of a member of the school staff.

FURTHER, we (I) understand that the school personnel are not legally obligated to administer medication to any child, and therefore, we (I) agree to hold the school district and its employees free from any and all responsibility for the results of such medication or the manner in which it is administered or not administered and to indemnify each of them against loss by reason of any civil judgment arising out of these arrangements which may be rendered against them.

FURTHER, we (I) agree to deliver the medication to the school in a container from the prescribing physician, dentist, or licensed pharmacist, properly labeled by same, this label to include name of students, physician, date, dosage, instructions, and name of medication.

FURTHER, we (I) will notify the school immediately of any change in physician or medication, or the termination of the medication for any reason, and will report immediately to the school to pick up the remainder of said medication.

Signature of Father/Guardian _____ **Date** _____

Signature of Mother/Guardian _____ **Date** _____

Address _____

Home Phone _____ **Work Phone** _____

PART III—TO BE COMPLETED BY SCHOOL

Signature of Nurse _____ Date _____

Signature of Director_____ Date _____

Please return directly to the School Nurse or fax to 937-502-4400