TOMORROW RIVER SCHOOL DISTRICT
REQUEST FOR GIVING MEDICATION AT SCHOOL

Request for Giving Medication **form is acceptable for all forms of medication with the exception of inhalers. Please see the Asthma form for consent for inhaler use at school. This form is available in your student's school office.**

AMHERST SCHOOL (Circle one): Elementary Middle High GRADE: _____ TEACHER: _____

I request: _____ _____
(Student Name) (Date of Birth)

Receives the medication prescribed by: _____ _____
(Physician's Name) (Phone number)

_____
(Physician's Address)

Note: All medication (both prescription and over the counter) is to be furnished by the parent and is to be in an original container. If a prescription medication, ask the pharmacist to divide the medication into two completely labeled containers, providing one for home and one for school.

Please fill in all information below:

Name of medicine: _____ Exp. Date: _____

Reason for medication: _____

Amount to be given: _____

Route: by mouth injection other_____

Time of day to be given: _____

For the period from: Date:_____ to Date:_____

Possible side effects: _____

I hereby give permission to designated school personnel to give medication to my child during the school day, including when away from school property on official school business, according to the written instructions of the doctor as shown on this form. I also hereby agree to give my permission to the school nurse and/or school personnel to contact the child's physician if needed.

I hereby give permission to designated school personnel to notify other appropriate school personnel and classroom teachers of medication administration and possible adverse effects of the medication.

I further agree to hold the Tomorrow River School District, and the employee(s) who is (are) administering the medication harmless in any or all claims arising from the administration of this medication at school.

I agree to notify the school at the termination of this request or when any change in the above orders is necessary.

_____ _____
(Date) **(Signature of Parent/Guardian)**

_____ _____
(Date) **(Signature of School Nurse)**

_____ _____
(Date) **(Signature of Physician-MUST have for prescription medication)**