

If it becomes necessary for a student to take medication or receive treatment during the school day, the parent or guardian must complete this request form and file it in the school nurse's office. If the medication or treatment is physician-prescribed, the parent or guardian must provide a written prescription from the child's physician or the current pharmacy label with the request. A physician's order is also necessary for prescription samples that may have been provided to the student, or for any over-the-counter medication that is not recommended for children under age twelve.

All other over-the-counter medication must be in the original container labeled with the student's name and date of birth. Label instructions will be followed for all over-the-counter medicine unless otherwise prescribed by a physician.

Parent's or Guardian's Authorization

I request that the medication described below be administered to my child/ward at the times specified during the school day. I will give the nurse the medication in its original container or current prescription bottle.

I understand that a parent or guardian will transport all medication to and from school. Medications must be picked up by the last day of school, or medications will be discarded.

I understand that a separate form must be completed for each medication. This request is in effect for one school year and must be renewed annually or whenever there is a change in medication.

I understand that this medication will be administered to my child only by authorized staff members and will be kept in a secure location within the school nurse clinic.

For medication requiring refrigeration, I acknowledge that while my student's medication is stored in the school clinic, the school corporation and Community Health Network do not assume liability for temperature variation that may result in loss of product viability. Parent/guardian will be responsible for product replacement. Refrigerator temperatures are monitored daily on school days.

_____	Student's Date of Birth: _____ / _____ / _____
Student's Name (Please Print)	Month Day Year
_____	Prescribed _____ Over-the-Counter _____
Name of Medication	
_____	Times(s) to administer _____ a.m. _____ p.m.
Days Medication to be given	
_____	_____
Amount of Medication to be given	Purpose of Medication
_____	_____
Signature of Parent or Guardian	Date
_____	_____ / _____
Printed Name	Primary Phone# / Secondary Phone#