SCHOOL DISTRICT
SD of PC
PICKENS COUNTY
Building success beyond the classroom

REQUEST FOR MEDICATION ADMINISTRATION

POLICY JGCD-E (2)

Student Name _____ Date of Birth _____

School _____ Grade _____

Medication _____ Dosage _____

Purpose of Medication _____

Time (s) medication is to be given during the school day _____

Possible side effects _____

Period of time medication may be administered: _____

_____
Physician's Signature REQUIRED

_____
Physician's Name

_____
Address

_____
Phone

I hereby request that _____ (student's name) be administered the above medication at school as indicated above. I understand that it is my responsibility to furnish this medication directly to the nurse or his/her designee and that the medication will be in its original container and labeled with the name of the student, the name of the medication, amount to be given, time of day to be given, and physician's name, if prescribed medication. While every effort will be made to properly address any noted side effects or adverse reactions, I understand that school officials cannot be held responsible for any negative consequences resulting from taking this medication.

_____
Print name of Parent/Guardian

_____
Signature of Parent/Guardian

Date ___/___/___