Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grade: \_\_\_\_\_\_\_\_\_\_\_

**TO BE COMPLETED BY PHYSCIAN:**

**\*Diagnosis for Medication:\* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Medication Name** | **Dose** | **Time To Be Given**  \*If **PRN** please indicate how often medication can be given\* | **Route** | **Side Effects** | **Special Instructions**  (Such as “take with food” or “crush pill”) |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**Start Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Stop Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If **PRN** (as needed) list symptoms /conditions under which medication is to be given: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician Signature Date Physician Printed Name**

**To be completed by parent/guardian:**

I am giving permission for my child\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to receive the above medication/treatment at school according to school district policy and for the physician and school district staff to share information regarding my child’s medication needs.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature Date

In consideration of the agreement of persons at the District to administer medication and/or medical procedures to , as requested by me and prescribed by a physician. I, on my own behalf, and on behalf of any other person associated with me, hereby agree to hold harmless and indemnify the Southgate Community School District, its Board of Education members, administrators, teachers, secretaries, and other employees, from any and all claims, damages, liabilities, demands, actions, causes of action, which may hereafter be asserted by any person, corporation, or other entity, against the parties listed above or against any other person associated with the Southgate Community School District under any legal theory based upon or arising out of circumstances related in any way to administration, by the District personnel, of medications or medical procedures to .

|  |  |  |
| --- | --- | --- |
| Witnesses: |  |  |
|  |  | Signature of Parent/Guardian |
|  |  |  |
|  |  | Telephone No. (Home) |
|  |  |  |
|  |  | Emergency Contact Name |
| Date |  |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Emergency Contact Number |