Grass Valley School District

Administration Of Medication At School

RR5250

Please have your physician/health care provider complete this form for all prescription or non-prescription medications.

1. Name of Pupil _____ Grade: _____
2. Birthdate _____ 3. School of Attendance _____
4. Medication(s) _____
5. Dosage, time and method of administration _____
6. Physical condition for which drug is to be given. (If allergic in nature, specify what type of reaction, i.e., localized, generalized, mild, severe). _____
7. Possible reactions that need to be reported to the physician/care provider. _____
8. Disposition of pupil following administration of medication, (i.e., rest, home, hospital, doctor's office, return to class, notification requests). _____

The above medication *cannot* be scheduled for other than during school hours and such medication may be administered by medically-untrained school personnel whenever necessary.

Physician/Health Care Provider Name _____ Phone _____

Address _____

Date of Request _____ Medication to be continued until _____ (Date)

_____

Authorization and Signature of Physician/Health Care Provider

I request that my child (the above named pupil) be assisted in taking the above medication at school by school personnel, and will comply with the policy and procedures of the school as outlined in the letter on the reverse side. I give my consent for the school nurse to communicate with the physician/health care provider and to counsel with school personnel regarding the above named pupil and medication as appropriate. I understand the school is not legally obligated to administer medication to any pupil and therefore agree to hold the district harmless from any liability resulting from the administration of above named medication(s).

_____ _____ _____

Authorization and Signature of Parent/Guardian **Date** **Phone Number**

3/97/bb