MEDICATION REQUEST AND RELEASE

(One Release per Medication)

Student Name:_____ Birth Date:_____

Address: _____

School:_____ Grade:_____ Teacher:_____

Parent/Guardian:_____

Home Phone:_____ Cell Phone: _____ Work Phone:_____

1. Licensed Health Care Practitioner's Name:_____ Phone Number: _____
2. Name/Type of Medication:_____

   _____
3. Dosage/Amount to be given:_____

   _____
4. Frequency/Times to be administered:_____
5. Possible reaction to medication (symptoms, side effects, etc.):_____

   _____

Licensed Health Care Practitioner's Signature:_____ Date:_____

Parent/Guardian Request/Approval:

I certify that I am the parent/guardian of the above named student. I request and authorize school personnel to dispense the above named medication in accordance with the prescription or Licensed Health Care Practitioner's orders. I have read the information regarding medication during school hours and agree to the provisions of Bonneville Joint School District No. 93 Policy #3510 *Dispensing Medications*. In making this request, I understand and agree to the following:

1. Unless the District otherwise agrees in writing, the District employee who will administer the medication to my child is not a nurse and has no medical or other health care training.
2. After giving medication to my child, said employee will be involved in other responsibilities and will not be able to monitor my child for adverse reactions to the medication.
3. Medication not approved for self-administration with a #3515F1 *Authorization of Self-Administered and Emergency Medication* form on file will be stored so that it is not easily accessible to students.
4. The District is not responsible for replacing the medication if it becomes lost or stolen.

Parent/Guardian Signature:_____ Date:_____

Principal Signature:_____ Date:_____