Request for Administration of Prescription Medication at School by School Personnel

To:______________________________, Principal, ______________________________School

Re: Student Name____Grade________

We (I), the undersigned, with the complete understanding that school personnel are not legally obligated to administer medication to at school, request the administration of medication during the 20____ - 20____ school year to this student.

We (I), as parents or legal guardians expressly assume liability and agree to indemnify and hold harmless the Berkshire Local Schools, its employees, servants and agents from all liabilities, claims, demands and actions by said student or any person on behalf of said student for any injuries that may have been caused, or alleged to have been caused, directly or indirectly, or by any act of omission or commission, negligent or otherwise, by the Berkshire Local schools, Its employees, servants and agents in connection with the administration of the medication herein requested.

We (I), shall be responsible to notify the school immediately if the medication is terminated for any reason, or treatment of the illness changes. We understand that medication must be in its original container and stored in the school office. We assume responsibility for delivering prescription medication in person to the school office or nurse.

Signature of Custodial Parent/ Guardian:
____Date: _______
Address: ____
Daytime Phone Number(s): ____

To be filled out by prescribing physician:

Name of Student: _____________________________________ Age: __________

Nature of Illness: ____

Medication: ____

Dose: ____

Time of Administration: ____

Side Effects to Report: ____

Discontinue Medication on (Date):______________________________________

Name of Physician: ____

Signature Of Physician: ______________________________________Date: _______

Address: ____

Phone Number: ____

02/04