

**Berkshire Local Schools
Medication Administration Request Form**

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 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 or clinic. We assume responsibility for delivering medication in person to the school office or nurse.

Signature of Custodial Parent/Guardian: _____ Date: _____

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): _____

Grades 7-12 Only:

Is able to carry/ self administer: Rescue Inhaler____ Epinphrine____ Insulin____

Name of Physician: _____

Signature of Physician: _____ Date: _____

Address: _____

Phone Number: _____ 08/19