

JLCD-FORM PARENTAL REQUEST FOR GIVING PRESCRIBED MEDICATION AT SCHOOL

**EPPING SCHOOL DISTRICT
PARENTAL REQUEST FOR GIVING PRESCRIBED MEDICATION AT SCHOOL**

I request the Nurse or staff member assist my child, _____,
(Name)
in taking the medication prescribed, _____
(Name of Medication)

Prescription Number _____ Druggist _____

by Dr. _____, for the period from _____
(Date)
to _____. (Not more than one month of prescribed medicine
(Date) may be stored in school.)

The medication will be delivered directly to the School Nurse, Principal or designated staff member by the parent or guardian, if possible.

The medication will be delivered in a container properly labeled with the student's name, the physician's name, the date of original prescription, name and strength of medication and directions for taking by the student.

I, the parent or guardian, agree by signing this request and "Hold Harmless" statement that I shall not hold liable any member of the school staff who is directed by me to assist my child in taking said medicine.

Signature _____

Date _____

School _____

APPROVED: September 22, 2005