JHCDE-1 - REQUEST FORM TO ADMINISTER MEDICINE

Highmore-Harrold School District
Elementary

Name of Student:_____ Birth date:_____

Address:_____Phone:_____

Parent/Guardian:_____

WE ENCOURAGE MEDICATION HOURS BE ARRANGED OUTSIDE OF SCHOOL HOURS IF POSSIBLE. MEDICATION MUST BE IN ORIGINAL CONTAINER. PARENT OR RESPONSIBLE DESIGNATED ADULT MUST DELIVER THE MEDICATION TO SCHOOL. ALL MEDICATION WILL BE STORED IN THE OFFICE IN A LOCKED CONTAINER, INCLUDING OVER THE COUNTER MEDICATION.

Diagnosis:_____

Name of medication/treatment:_____

Total Daily Dosage:_____

Amount & Times to be administered at school:_____

Method of administration:_____

Duration {week, month, year}:_____

Precautions and reactions to observe and report:_____

_____

_____

Physician's Signature:_____

Physician's phone number:_____

Parent's Statement:

I request and authorize personnel at the Highmore-Harrold School District to supervise the medication/treatment prescribed on this form to my child. I understand the medication must be provided in a bottle, identifying the name and telephone number of the pharmacy, the student's name, physician's name and dosage of the drug taken. I understand that the school district and individuals involved will not be held liable for any adverse effects of the medication. In addition, I understand that I am responsible to deliver the medication to the school and to pick up unused medication on or before the last day of school or one week after the last dose is given. If the medication is not picked up, it will be destroyed.

_____ _____

Parent's Signature Date