

CLOVERLEAF LOCAL SCHOOL DISTRICT  
PHYSICIAN'S REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL

To \_\_\_\_\_ School Personnel  
(Name of School)

It is requested that the medication, as indicated below, be administered by school personnel. This medication for the student listed below may be necessary during school hours and it is understood that the administration of such medication may be provided by medically untrained personnel.

Name of student \_\_\_\_\_

Address of student \_\_\_\_\_  
(street) (post office) (zip)

Medication to be administered (name and dosage): \_\_\_\_\_

Instructions/conditions for administration and/or self-administration: \_\_\_\_\_  
\_\_\_\_\_

Has the student demonstrated competence to carry and self-administer this medication? \_\_\_\_\_

Possible reactions that, if they occur, should be reported to the physician: \_\_\_\_\_  
\_\_\_\_\_

Procedure to follow in the event that the medication does not produce expected relief: \_\_\_\_\_  
\_\_\_\_\_

Procedure to follow in the event that the medication is used by a student for whom it has not been prescribed: \_\_\_\_\_  
\_\_\_\_\_

Medication to start \_\_\_\_\_ and to continue until \_\_\_\_\_.  
(date) (date)

Date of this request \_\_\_\_\_.

Physician's signature \_\_\_\_\_

Physician's address \_\_\_\_\_  
(street) (post office) (zip)

Physician's telephone number \_\_\_\_\_

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To be completed by school:

Person(s) authorized to administer medication for this student (principal should list name(s):  
\_\_\_\_\_  
\_\_\_\_\_

Nurse's signature \_\_\_\_\_ Date \_\_\_\_\_

Principal's signature \_\_\_\_\_ Date \_\_\_\_\_

CLOVERLEAF LOCAL SCHOOL DISTRICT

PARENT RELEASE FORM FOR ADMINISTRATION OF MEDICATION AT SCHOOL

To \_\_\_\_\_ School  
(Principal's Name) (School Name)

For \_\_\_\_\_ Grade \_\_\_\_\_  
(Student's Name)

We (I), the undersigned, who are the parent(s), foster parent(s), guardian(s), (*cross out those not applicable*) of \_\_\_\_\_, request that oral medication or inhaler be administered to our child in accordance with the instructions of our physician, Dr. \_\_\_\_\_. We (I) understand that the administration of said medication is to be done under the supervision of a member of the school staff.

Further, we (I) understand that the school personnel are not legally obligated to administer medication to any child, and, therefore, we (I) agree to hold the school district and its employees free from any and all responsibility for the results of such medication or the manner in which it is administered and to indemnify each of them against loss by reason of any civil judgment arising out of these arrangements which may be rendered against them.

Further, we (I) will notify the school immediately if we change physicians or medication or terminate the use of this medication for any reason.

\*Signature of Father \_\_\_\_\_

\*Signature of Mother \_\_\_\_\_

Address of parents \_\_\_\_\_  
(street/road) (post office) (zip)

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Date of signature(s) \_\_\_\_\_

(Oral medication refers to medication in pill form only. Liquid medication that must be measured cannot be administered. Also, the schools will not assume the responsibility for administering injections, applying ointments, or changing dressings.

\*Both parents must sign this release if they are living with or have custody of child. If parents are separated and both still retain legal custody, both parents must sign. If children are in foster home and placement is by agency that holds custody, agency must sign.