DEERFIELD COMMUNITY SCHOOL DISTRICT

Administering Medication to Students

(Please return to your child's school)

Student Name:_______________________________________

Birthdate:______________________ Male____ Female____

School:_________________________________ Grade_____

Parent/Guardian:_____________________________________

Home Phone:__________________ Work:________________

Physician's Name:____________________________

Physician's Address:__________________________

____

Physician's Phone:____________________________

Physician's Fax:______________________________

To Parent/Guardian/Physician:

The School District of Deerfield is required by state statute to give prescription medication to students only with the complete directions from a physician and signed consent by parent/guardian. Medication must be supplied in the original container or packaging. For safety and liability reasons, medication received in any container other than the original will not be acceptable for staff administration. By signing this form, you release the Board of Education, its agents and employees from any and all liability which may result from taking this medication.

(This form must be completed for each medication (if more than one) to be dispensed)

Medication:_______________________________________ Dosage___________ Frequency__________________

Start Date______________________ End Date_________________________

Form: ☐ Tablet/Capsule ☐Liquid ☐Inhaler ☐Nebulizer ☐Injection

☐For episodic/emergency events only ☐Other:____

**Emergency Medications (inhaler, glucagon, insulin, epi-pen). Students to self-administer/carry: ☐YES ☐No

Time(s) to be given:_______________________ Reason for medication:____

____

If given on an "as needed" basis, please describe:____

____

Special instructions:____

____

Side Effects (expected or predictable)____

____

I, the prescribing physician, am willing to accept direct communication from the person dispensing and administering the above medication:

Physician's Signature____ Date___________________________

(Signature required for all prescription medication)

Parent/Guardian Signature____ Date________________________

(Signature required for all prescription and nonprescription medication)