

SOUTH EASTERN SPECIAL EDUCATION

PARENT'S REQUEST TO ADMINISTER MEDICATION AT SCHOOL

I hereby request school personnel to administer the following medication to my child, _____ . I will hold harmless and save the South Eastern Special Education joint agreement, its Governing Board and employees from and against any and all actions or cause of action, claims, demands and liabilities, loss, damage, or expense whatsoever kind and nature which the Board of the South Eastern Special Education joint agreement, its Governing Board, and employees may at any time sustain or incur by reason and consequence of the administration of medication to my child. I also hereby agree to notify school personnel if there is any change in the medication being requested to be administered, or if my child is exhibiting any symptoms related to the administration of medication other than those designated below.

_____ **Date** _____ **Parent or Legal Guardian's Signature**

NOTE: School will accept Parent or Guardian signature only. Please have your physician complete the following information and return this form to the school as soon as possible. Please notify us immediately of any changes in medication.

Physician's Request to Administer Medication

Student's Name _____ Date of Birth _____

Physician's Name _____

Physician's Phone _____ Physician's Emergency Phone _____

Name of Medication _____

Dosage _____

Route of Administration _____

Frequency and Time of Administration _____

Is it necessary to administer this medication during the school day? _____

Date of Prescription _____ Date of Order _____

Discontinuation Date _____

Diagnosis Requiring Medication _____

Intended Benefits of the Medication _____

Possible Side Effects _____

Time Interval for Re-evaluation _____

Name(s) and dosage(s) of other medication(s) the child is receiving: _____

Are there any other problems we should know about, such as seizure disorders, hernia, which would prevent lifting, or any other medical or physical problem of which the school should be aware?

_____ **Date**

_____ **Physician's Signature**