DISTRICT TWO HARRISON SCHOOLS

Harrison D2
Student Medication Form

Name of student _____

Date of Birth _____ School _____

Medication _____ Dosage _____

_____

Time of day medication is to be given _____

Possible side effects _____

Anticipated number of days medication is to be given _____

Date _____ Provider Signature_____

_____ Phone number_____
Print Provider's name

Student is allowed to self carry inhaler or epipen _____
Providers Initials

It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. In consideration of the acceptance of the request to perform this service by the school nurse or other designee employed by Harrison District Two, the undersigned parent of guardian hereby agrees to release Harrison District Two and its personnel from any legal claim which they now have or may hereafter have arising out of the administration of or failure to administer the medication to the student.

I hereby give permission for (name of student) _____
To take the above prescription at school as ordered. I understand that it is my responsibility to furnish this medication.

Date_____Parent/Guardian_____

Note: the prescription medication is to be brought to school in a container appropriately labeled by the pharmacy or physician stating the name of the medication and the dosage.

District Nurse Signature_____ Date_____