ELLWOOD CITY AREA SCHOOL DISTRICT

Physician and Parent Request for Administration of Medication During School Hours

If it is essential that the student receive medication during school hours, please complete the following information and return to school with each medication in a doctor prescribed bottle:

Student Name _____ Grade_____

Diagnosis _____

Name of Medication _____

Dosage _____ Route _____ Time _____

Side Effects or Activity Limits _____

List any other medication prescribed _____

_____

_____

Physician Signature Date Telephone #

PARENT/GUARDIAN STATEMENT

I give my permission for the prescribed medication to be given during school hours and I relieve the school district and its employees of any responsibility for the benefits and/or consequences of taking or omitting the medication.

_____

Parent/Guardian Signature Date