School District of Crandon Medical Release Form

All portions of this medical request form must be completed before medication can be administered by school district personnel. Prescription medications require a physician's signature.

STUDENT: _____ SCHOOL _____

GRADE: _____ TEACHER: _____

NAME OF MEDICATION _____

STORAGE REQUIREMENTS: _____

DOSAGE: _____ TIME(S) TO BE GIVEN: _____

HOW TO BE GIVEN (oral, injection or other).
EXPLAIN: _____

REASON FOR MEDICATION:
_____

DATE OF DISCONTINUATION: _____

Explain possible reactions or other instructions: _____

PHYSICIAN'S NAME: _____ PHYSICIAN'S PHONE _____

The school personnel have my permission to administer this medication as indicated above. I agree to hold the School District of Crandon, its employees or agents who are acting on this request, harmless in any and all claims arising from the administration of this medication at school. I also agree to inform the school immediately and in writing of any change in the medication order.

I further give permission to the school authorities to contact the child's physician, if necessary.

Parent/guardian signature: _____ DATE: _____

Home phone number: _____ Work phone number: _____

PHYSICIAN AUTHORIZATION
The physician whose signature follows hereby authorizes school personnel to administer medication as prescribed and also agrees to accept communication regarding the administration procedures. It is understood that the medication will be given by non-licensed, but specially trained personnel. The reason(s) that the medication must be given during the school day should be given.

Medical rationale for medication to be given during the school day:

Physician's signature: _____ Phone # _____ Date _____