



The Summit Country Day School
SCHOOL POLICY REGARDING THE DISPENSING OF MEDICATION AT SCHOOL
PRESCRIBED BY A PHYSICIAN

In order for school personnel to administer prescribed medications to a student, the following information must be on file (this form is to be completed in full and turned in to the School Nurse).

Name of Pupil: _____ Date of Birth: _____

Address: _____ Zip Code: _____ Phone: _____

School: _____ Grade: _____

TO BE COMPLETED BY THE CHILD'S PHYSICIAN:

Name of Medication: _____

Dosage: _____

Duration of Dosage: _____

How Administered: _____

Date to Begin Administering Medication: _____

Date to Terminate Administering Medication: _____

Possible Side Effects: _____

Physician's Name (print or type): _____

Physician's Phone: _____ Physician's Emergency Phone: _____

Special Instructions for Re-administering/Storing of Medication: _____

Physician's Signature: _____

NOTE: The medicine must be in a clearly marked container from the pharmacist. The label must show the child's name, the dosage directions, the doctor's name and the prescription number.

TO BE COMPLETED BY THE PARENT: The undersigned agree not to file or make any claim against anyone for the negligence in connection with the administration or non-administration of any medicines and further agree to save such individuals and hold them harmless from any liability incurred as a result of the administration or non-administration of any medicines.

I give my permission for the Nurse or his/her designee to administer the prescribed medication.

Signature of Parent/Parent Surrogate

Date:

-- THIS PERMISSION IS NO LONGER VALID AT THE END OF THE CURRENT SCHOOL YEAR --

.....Revised April, 2000.....

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