

PARENT’S REQUEST FOR GIVING MEDICATION OR TREATMENT AT SCHOOL

My child, \_\_\_\_\_, a student in \_\_\_\_\_ School requires medication and/or a medical procedure during the school day as prescribed by his/her physician. I hereby authorize the designated staff person to administer the medication/procedure prescribed below according to the directions. In consideration of the service, I (we) further hereby agree that I (we) will not hold liable, and will otherwise hold harmless, the Windham School District and any such member of the administration of the medication/procedure described below. This includes permission to confer with the physician, if necessary.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

**PHYSICIANS’ STATEMENT**

The above named student, \_\_\_\_\_, requires medication and or a medical procedure during the school day as follows:

Diagnosis: \_\_\_\_\_

Mediation: \_\_\_\_\_ Dosage: \_\_\_\_\_

Time: \_\_\_\_\_ Frequency/ Duration: \_\_\_\_\_

Route of Administration: \_\_\_\_\_

Possible side effects, adverse reactions, and contraindications:  
\_\_\_\_\_  
\_\_\_\_\_

Other medications the student is currently taking: \_\_\_\_\_

Identification of medical procedure (explanation and details, i.e., time and duration);  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_ Signed: \_\_\_\_\_

(Physician)

Physician Telephone # \_\_\_\_\_ Print Name \_\_\_\_\_

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All medication (over the counter and prescribed) must be in the original pharmacy labeled container and accompanied by this signed form.