BRIGHT LOCAL SCHOOL DISTRICT
ADMINISTRATION OF PRESCRIBED MEDICATION

PART 1: TO BE COMPLETED BY PHYSICIAN

NOTE: Whenever possible medication should be scheduled so the student does not have to take medication during school hours.

1. Student ______________________________________ 2. Grade/Teacher_____________________________

3. Address ____

4. Medication to be administered and procedure: ____

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5. Side effects to be reported: ____

6. Special instructions (duration, storage, etc.): ____

7. Physician's Name ____ Phone ___________________________

8. Address ____

9. Physician's Signature ____ Date _________________________

PART II: TO BE COMPLETED BY PARENT OR GUARDIAN

We (I) understand that the administration of said medication is to be done under the supervision of a designated school personnel.

Further, we (I) understand that the school personnel are not legally obligated to administer medication to any child and, therefore, we (I) agree to hold the School District and its employees free from any and all responsibility for the results of such medication or the manner in which it is administered and to indemnify each of them against any loss by reason of any civil judgment arising out of these arrangements which may be rendered against them.

Further, we (I) agree to deliver the medication to the school in the original container from the prescribing physician or licensed pharmacist, properly labeled by same, this label to include name of student, physician, date, dosage instructions (quantity and times), and name of medication.

Further, we (I) will notify the school immediately if we change physicians or medications or terminate the use of this medication for any reason, and will report immediately to the school to pick up the remainder of said medication.

1. Signature of Parent/Guardian____ Date _______________________

2. Home Telephone _________________________________ Work Telephone ___________________________________

PART III- TO BE COMPLETED BY THE SCHOOL

1. ____ Date _________________________________
Signature of Nurse (or person who will administer the medication)