CENTRAL KITSAP SCHOOL DISTRICT
Health Services

PHYSICIAN'S ORDER FOR MEDICATION AT SCHOOL

In order for children to receive medication while at school, the following form must be completely filled out and returned to the school prior to its administration.

I request the following student be given medication during the school day:

Name of student: ____ DOB______________________

Condition being treated: ____

Name of medication: ____

Dosage to be administered: ____

Time to be given at school: ____

Inclusive dates for medication to be given: ____

Side effect of drug to be expected, if any: ____

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Action required if side effects occur: ____

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Name of Physician: ____ Phone: __________________
(Please print)

Health Care Provider: ____
(Please print)

Signature of Physician: ____Date:____________________

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PARENT'S REQUEST FOR MEDICATION AT SCHOOL

I request that a designated staff member give my child, ____

_________________________, the medication prescribed above by Dr. ____________________________

I will deliver the prescribed medication to the school in the original pharmacy container with the label intact. If I want to discontinue this medication prior to the date indicated by the physician, I will make that request in writing.

I agree to hold Central Kitsap School District #401 harmless from any liabilities it may incur in connection with this requested medication at school when the medication is administered in accord with this physician's written direction.

____ _________________________

(Signature of parent or guardian) (Date)

This request will expire at the end of the current school year.

(Rev. 9/02)