

**HARDIN NORTHERN LOCAL SCHOOL
MEDICATION FORM**

For Dispensing Medication by School Personnel

PHYSICIAN'S AUTHORIZATION:

Student Name _____ Grade _____

Student Address _____ Phone _____

**The above named student is under my care and should receive the following medication during the school day at the time and in the manner prescribed.

Name of Medication _____ Dosage _____

Time or interval medication is to be given _____

Starting Date for medication _____ Ending date _____

Describe possible reactions, which should be reported to the physician _____

Special instructions including sterility and storage _____

Date _____ Physician's signature _____

Medication will only be given at school when this top portion is completed and signed physician

Physician's phone number _____

PARENT OR GUARDIAN:

I request and give my permission to the principal or his delegate (school nurse or other responsible person) to administer the following medication to my child according to the above instructions.

Name of student: _____ Name of Medication _____

I agree:

1. Parent/Guardian or other adult will deliver the medication to school in the original container properly labeled. The student is not to transport the medication.
2. Written notification to the school by a physician if medication or dosage is changed or stopped. Or changes in physician ordering medication.
3. The school nurse has the right and responsibility to communicate with the physician regarding the administration of any medication when prudent and in the best judgment and or interest of the child to do so.

Date _____ Parent or Guardian Signature _____

Phone Number _____ Address _____