# Anderson School District One
# School Health Services


# PRESCRIPTION MEDICATION

Dear Principal:
I request that a member of the school staff assist my child_____ _____ with medication, according to doctor's order. I understand that the principal or his/her designee may assist with the medication. I had my child's physician complete the required statement, naming the medication, the dosage, and the time the medication should be taken. I understand that it will be my child's responsibility to remind school officials of the time the medication is to be taken. I am aware that school employees are not licensed to administer injections or medications and have no special training in such procedures. I hereby agree not to hold the school district or school personnel liable for any adverse drug reactions when the medication is taken according to prescribed method. I understand that the school district/principal may deny this request for legitimate reasons.

**Parent Signature:_____Date_____**

## Doctor's Statement

Patient's Name:_____Date of Birth:_____
My patient needs to take the following:

| Medication | Dosage and Time | Adverse Reactions |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Diagnosis:_____
Date medication to begin:_____
Date medication to end:_____

It is district policy that the medication must be brought to the health room in the original labeled bottle or package.
***It is necessary for this child to take this medication while attending school:***

Physician's Signature:_____Date:_____
Telephone Number:_____
Fax Number: _____