School District of DEERFIELD
Administering Medication to Students
(Please return to your child's school)

Student Name____ Physician's Name_________________________

Birthdate__________________ Male________ Female______ Physician's Address_____________________

School____________________ Grade ___________________ ______________________________________

Parent/Guardian______________________________________ Physician's Phone________________________

Home Phone________________Work Phone________________ Physician's Fax__________________________

To Parent/Guardian/Physician:

The School District of Deerfield is required by state statue to give prescription medication to students only with the complete directions from a physician and signed consent by parent/guardian. Medication must by supplied in the original container or packaging. For safety and liability reasons, medication received in any container other than the original will not be acceptable for staff administration. By signing this form, you release the Board of Education, it's agents and employees from any and all liability which may result from taking this medication.

Medication____________________________________ Dosage_________ Frequency_________________________

Start Date_________________________ End Date_________________________

Form: ________Tablet/Capsule ________ Liquid ________ Inhaler _________ Nebulizer ________ Injection

_______ For episodic/emergency events only ______Other____

*Emergency Medications (inhaler, glucagon, insulin, epi-pen). Student to self-administer/carry: yes_______ No______________

Time(s) to be given__________________ Reason for this medication____

If given on an "as needed" basis, please describe____

Special instructions____

Side effects (expected or predictable)____

____

I, the prescribing physician, am willing to accept direct communication from the person dispensing and administering the above medication.

Physician's Signature____ Date____________________
(Signature required for all prescription medication)

Parent/Guardian Signature____Date____________________
(Signature required for all prescription and nonprescription medication).