St. John-Hudson USD 350

Request For Prescription Medication During School Hours

24/25 school year

Student name:_____ DOB:_____

Allergies/Reaction:_____ School year:_____

Medication:_____

Dosage:_____

Time of day medication is to be administered:_____

Anticipated number of days medication is to be administered at school:_____

Reason for RX:_____

_____ _____

Signature of Physician Date

I hereby request and give permission for the above named student to take the above named prescription medication at school as ordered. I understand that it is my responsibility to furnish this medication. I further understand that any school employee who administers any medication to my student in accordance with written instructions from the physician or dentist shall not be liable for damages as a result of an adverse reaction to the medication administered.

I hereby authorize USD 350 school nurse to exchange information regarding this request with the prescribing physician and with the pharmacy as identified on the affixed pharmacy label if clarification is required.

_____ _____

Signature of parent/guardian Date

Note: Medication brought to school must be in the original container with all labels intact. Label must include pharmacy name, student name, medication name and dosage. If you are giving the medication at home as well, please request two medication containers from the pharmacy.

Revised 2024 Please return to T Davis, RN