MILBANK SCHOOL DISTRICT MEDICATION REQUEST/RELEASE

I request and authorize officials at _____School to supervise administration of the Medication listed below at the indicated time(s) as prescribed by Dr. _____ or requested by _____.

STUDENT'S NAME _____ GRADE _____

MEDICATION_____ DOSAGE_____

TIME(S) _____ ROUTE_____

REASON FOR TAKING MEDICATION_____

PRECAUTIONS AND REACTIONS TO REPORT _____

I understand the medication shall be provided in a correctly labeled bottle showing the name and dosage of the medication to be taken, the student's name and the prescribing physician's name. I also understand that the Milbank School District and individuals involved will not be liable for any adverse effects of the medication. IT IS THE RESPONSIBILITY OF THE STUDENT TO COME TO THE OFFICE TO TAKE THIS MEDICATION.

PARENT OR GUARDIAN_____ DATE _____

PLEASE SIGN AND RETURN THIS FORM TO THE SCHOOL HEALTH OFFICE.