Prescription Medication

USD 240 Twin Valley Schools
Bennington #785-488-3323 Tescott #785-283-4774
fax #785-488-3750 fax #785-283-4347

Student:_____ Grade:_____

Diagnosis/Reason for Rx:_____

Medication:_____

Dosage:_____ Time:_____ Route:_____

Start Date:_____ Stop Date:_____

Side effects/adverse reactions to monitor:_____

Printed name of prescribing physician:_____

Physician Signature:_____ Date:_____

I hereby give my permission for:_____to take the above prescription at school as ordered.

I understand that it is my responsibility to furnish this medication. I understand that the medication is to be brought to school in the original container appropriately labeled by the pharmacy, or physician, stating the name of the student, name of the medication, the dosage, and time(s) it is to be administered. Please talk to your pharmacist about an extra bottle for home/school.

I further understand that any school employee who administers the above 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 medication reaction suffered by the student as a result of administering such medication. I further acknowledge that the above student has taken the medication(s) previously (or the initial dosage) and did not have an adverse medication reaction.

Date_____ _____
(Signature of Parent or Guardian)

Date_____ _____
(Signature of School Nurse)