REQUEST AND AUTHORIZATION FOR MEDICATION TREATMENT

Garretson School District 49-4
505 2nd St, PO Box C
Garretson, SD 57030

☐ **Option 1:** Please check this option if your student does **NOT** receive medication at school on a daily basis. This option must be signed in the event you send over-the-counter medications such as cough drops, one dose of acetaminophen/ibuprofen, inhaler, etc. to school with your student at any time throughout the year. I authorize my child to take his/her own medication while at school and I relieve the school district and personnel of all responsibility. **I understand my child must keep the medication on him/her at all times and may not leave it in lockers, etc.** A doctor's signature is not required.

Student's Name ____

Parent/Guardian's Signature ____

Date _________________________________

☐ **Option 2: (Medication taken daily)** I request and authorize personnel at the Garretson School District to supervise the medication/treatment prescribed to my child on this form. I understand the medication must be provided in a pharmacy or manufacturer-labeled container, identifying the name and telephone number of the pharmacy, the student's name, physician's name, and correct dosage of the drug to be taken. I understand that the school district and individuals involved will not be held liable for any adverse effects of the medication. In addition, I understand that I am responsible for picking up unused medication on or before the last day of school or within one week after the last dose has been given. If the medication is not picked up, it will be disposed of. **A doctor's signature is required for this option.**

Student's Name _______________________________________ Date of Birth ___________________

Address ____

Parent/Guardian's Name ______________________________________ Phone ____________________

MEDICATION/TREATMENT TO BE ADMINISTERED DURING SCHOOL HOURS

1. Diagnosis/reason for medication/treatment ____
2. Name of medication/treatment ____
3. Total daily dosage ________________________ Method of administration _______________
4. Amount and time(s) to be administered AT SCHOOL ______________________________________
5. Duration: continue throughout school year ____ Discontinue on this date ___________
6. Precautions or reactions to observe/report

____ _____________________________
Physician's Signature (Required for Option 2) Date

If your child should need short term prescription medication, please schedule his/her doses outside of school hours, if possible.

A NEW FORM NEEDS TO BE COMPLETED AND RETURNED TO THE OFFICE BY EVERY STUDENT AT THE BEGINNING OF EACH SCHOOL YEAR.