

PARENT RELEASE FOR THE ADMINISTRATION OF ORAL MEDICATION
OR MEDICAL PROCEDURES AT SCHOOL
(To Be Completed by Physician)

To the Reading Community School District personnel:

Since medication for the student listed below cannot be scheduled for other than school hours and the administration of such medication may be supervised by medically untrained personnel, it is requested that the oral medication or medical procedures, as indicated below, be administered by school personnel.

The school will supervise administration of oral medication in pill form or premeasured liquid medication and injections of epipen and insulin. It will not assume responsibility for administering liquid medication that must be measured, application of ointments, or change of dressings.

Name of student: _____

Address of student: _____

Medication/medical procedure: _____
(name, quantity, and times of day) _____

Possible reactions that, if they: _____
occur, should be reported to parent _____
and physician _____

List special instructions including: _____
storage and sterile requirements _____

Medication should begin on: _____ and continue through: _____

Date of this request: _____

Physician's name and signature: _____

Physician's address: _____

Physician's telephone number: _____ emergency number: _____

TO BE COMPLETED BY SCHOOL

Signature of person(s) designated by the building principal to administer medication or medical procedures for this student. Principal should list name(s). Designee must have a copy of the parent release and the most recent physician's statement.

Name _____ Signature _____ Date _____

Name _____ Signature _____ Date _____

Principal's signature _____ Date _____