Physician's Request for the Administration of Oral Medication or Medical Procedures at School

TO BE COMPLETED BY PHYSICIAN

To the Reading Community School District Personnel:

Since the 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 pre-measured liquid medication and injections or EPI-pen and insulin. It will not assume responsibility for administering liquid medication that must be measured, application or ointments, or change of dressings.*

Student's Name _____

Student's Address _____

Medication/Medical Procedure (medication name, dose, frequency/time of day):

_____

_____

Possible reactions that should be reported to a parent and physician upon occurrence:

_____

_____

_____

Special Instructions including storage and sterile requirements:

_____

_____

Medication/procedure should begin on ___/___/___ and continue through ___/___/___

Physician's Address_____

Office Number (___) _____-_____ Emergency Number (___) _____-_____

Physician name (printed)_____

Physician signature_____ Date_____

For School Use Only

Signature of person(s) designated by 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.

Printed Name_____Signature_____Date_____

Printed Name_____Signature_____Date_____

Principal's Signature_____Date_____

Parent Release for the Administration of Prescription Medication or Medical Procedures at School

To the Principal of:

- ☐ Central Elementary
- ☐ Hilltop Elementary
- ☐ Reading Middle School
- ☐ Reading High School

We (I) the undersigned who are the ☐parent(s) ☐guardian(s) of _____ request that oral medication or procedures be administered to our child. We (I) understand that the administration of said medication or medical procedure is to be done under the supervision of a member of the school staff.

Further, we (I) understand that the school personnel may not be legally obligated to administer oral medication or medical procedures to any child, and therefore, we (I) agree to hold the school district and its employees free from any and all responsibility for the results of such medication or medical procedures or the manner in which they are administered and to indemnify each of them against loss by reason of any civil judgment arising out of these arrangements which ay be rendered against them.

Further, we (I) will notify the school immediately if we change medication or terminate the use of this medication for any reason. If a physician or medication change occurs, we (I) will submit a revised doctor's statement.

Notes for Parents:

- MEDICATIONS MUST COME TO THE SCHOOL IN ORIGINAL PACKAGING.
- ALL MEDICATIONS MUST BE TURNED INTO THE SCHOOL OFFICE, with the exception of EPI-pens or Asthma inhalers, which may be kept on the student if necessary.

Medication_____

Amount_____ How Often_____

Reason for Medication_____

Check the appropriate box if you are also granting your permission for your child to carry his/her ☐ Inhaler ☐ EPI-pen on his/her person.

Signature of parent/guardian _____Date____/____/____

Address of parent/guardian_____

Home Phone (____) _____-_____ Work Phone (____) _____-_____

Cell Phone (____) _____-_____