School District of Johnson Creek
Administering Medication to Students
(Please return to your child's school)

Student Name_____ Physician's Name_____

Birth date_____ Male _____ Female _____ Physician's Address_____

School_____ Grade_____ _____

Teacher (if applicable)_____ Physician's Phone_____

Parent/Guardian_____ Physician's Fax_____

Home Phone_____Work Phone_____

Cell Phone_____

To Parent/Guardian/Physician:

The School District of Johnson Creek is required by state statue to give prescription medication to students only with the complete directions from a physician and signed consent by parent/guardian. Medication must by supplied in the original container or packaging. For safety and liability reasons, medication received in any container other than the original will not be acceptable for staff administration. By signing this form, you release the Board of Education, its agents and employees from any and all liability which may result from taking this medication.

Start Date BOSY End Date EOSY
Beginning of school year (BOSY) End of School Year (EOSY) = July 30

Medication_____ Dosage_____ Frequency_____

Medication Expiration Date (if applicable)_____

Form: • Tablet/Capsule • Liquid • Inhaler • Nebulizer • Injection • Other_____

• For episodic/emergency events only. (Emergency medications such as: inhaler, glucagon, insulin, Epinephrine).

Student to self-administer/carry: • Yes • No

Time(s) to be given _____ Reason for this medication _____

If given on an "as needed" basis, please describe_____

Special instructions_____

Side effects (expected or predictable)_____

Physician's Signature_____ Date_____
(Signature required for all prescription medication and for non-prescription medication, which exceeds the manufacturer's recommended dosage).

Parent/Guardian Signature_____Date_____
(Signature required for all prescription and non-prescription medication).