



Douglas County School District

Student Health Services

Medication Assistance Request for School: _____ **Year:** _____

1. I request that personnel from the Douglas County School District assist my child with the medication noted below. I give permission to the school nurse to discuss the medication with the physician named below.
2. Prescription Medication:
 - a. Must be in a prescription bottle; ask the pharmacy for a second labeled bottle to be used at school.
 - b. Must receive physician signature, school may fax the physician as a courtesy, if prompt reply is not received parent/guardian will need to obtain signature by physician.
 - c. All controlled substance (Ritalin, Adderall, pain relievers, etc.) must be brought and picked up by parent/guardian. These medications also require a "count" check in with the nurse at the school.
 - d. Changes in medication require a new form, new physician signature, and new pharmacy bottle – it is the parent/guardian responsibility to notify the nurse of any changes (new physician, change in health status).
3. Over the counter medication:
 - a. Must be provided in a small, original labeled container – no baggies or envelopes. Must be accompanied by this form.

Student: _____ Birth Date: _____
Medication: _____ Dosage: _____
Dosage Time: _____ Start Date: _____ End Date: _____
Student to carry EPI Pen/Inhaler on person: _____
Physician's Signature Required: _____
Reason for Medication: _____

This medication will be provided by the parent/guardian and the parent/guardian agrees to assume all the responsibility for maintaining the supply of the medication to the school.

The undersigned parent/guardian hereby requests the Douglas County School District, through Student Health Services or school staff, to assist their child taking the above described medication as set forth and consents to medication assistance during the school day and/or at school functions. The parent/guardian hereby expressly relieves the Douglas County School District, Board of Trustees of the district and all agents of the district from any liability for the administration of such medication, and further hereby agrees to hold the Douglas County School District, the Board of Trustees of the district, and all agents of the district harmless from any liability for their participation in assisting the above named student in taking this medication.

Parent/Guardian Signature: _____ Date: _____

Physician Signature: _____ Date: _____

School Nurse: _____ Date: _____