LAMONI COMMUNITY SCHOOLS
PRESCRIPTION MEDICATION RELEASE

Student_____Age_____Grade_____

Reason for giving this medication (a.e. ADHD, infection, seizures)_____

_____

Name of Medication (example-Amoxil 250mg)_____

Dosage (example-one tablet)_____

Time (circle)_____8:00 am_____12:00 noon_____Other_____

Starting Date_____ Ending Date_____

Amount Sent_____

_____The student has taken this medication previously and experienced no side effects. (Y or N)

_____First dose will be given at school (Y or N)

I request that the prescribed medication be dispensed according to above directions which also comply with label. I further agree that school personnel may contact the prescriber as needed and that medication information may be shared with school personnel as deemed necessary.

I understand the law provides that there shall be no liability for damages as a result of the administration of medication where the person administering the medication, acts as an ordinary, reasonable prudent person would under the same circumstances and that the school district and the school nurse are to incur no liability, except for gross negligence.,

Parent/Guardian_____

Signature_____

Date_____ Home Phone #_____

Work Phone #_____

Cell Phone #_____

MEDICATION WILL NOT BE GIVEN IF IT HAS EXPIRED OR IT HAS AN IMPROPER LABEL. PLEASE CHECK THE CONTAINER BEFORE SENDING IT TO SCHOOL.

Ask your pharmacist for a bottle labeled for school use.