PARENTAL REQUEST AND PHYSICIAN'S ORDER FOR MEDICATION
*(For use in requesting the school's service when medication **must** be given during the school day by the school medication designee)*

TO BE COMPLETED BY PARENT/GUARDIAN:

_____ _____ _____
Child's Name Date School

I request that my child (named above) be given the medication as indicated in the physician's order below. I am aware that non-medical personnel will be administering this medication to my child. I hereby release the Catawba County Schools, their agents and their employees from any and all liability that may result from my child taking the prescribed medication.

_____ _____ _____
Parent/Guardian Signature Telephone Date

TO BE COMPLETED BY THE PHYSICIAN (For use **only** when medication **must** be given during the school day in order for the student to maintain his/her authorized medication plan)

Name and Form of Medication: _____

Dosage: _____

Times to Be Given: _____

Route of Administration: _____

Other Specific Directions: _____

_____

Purpose of Medication: _____

Side Effects to Watch For: _____

Duration of Order: _____

_____ _____
Physician's Name and Address (Please Type and/or Print) Telephone Number

Physician's Signature: _____

Thank you for completing this form.