ROCHESTER AREA SCHOOL DISTRICT
PRIVATE PHYSICIAN REQUEST FOR ADMINISTRATION OF MEDICATION
DURING SCHOOL HOURS

It is our procedure to request that medication be given before or after school hours whenever possible. If it is essential that the students receive the medication(s) during school hours, please complete the following information.

Student Name_____Grade_____

Name of Medication(s)_____

Purpose of Medication(s)_____

_____

Dosage_____

Time schedule for administering medicine_____

Duration of medication administration_____

Possible SIDE EFFECTS or contraindications_____

Procedure to follow if reaction should occur_____

_____

Curtailment of specific school activity (sports, shop, lab, etc…)_____

_____

Other medications that student is taking OUTSIDE OF SCHOOL HOURS_____

_____

Is STUDENT capable of SELF-ADMINISTRATION_____

Physician's Signature_____Date_____

Print Physician's Name_____Physician's Telephone #_____

I hereby authorize the medication listed above to be administered to my child by the school nurse of other designated person. I release the Rochester Area School District and all its employees for any and all liability for damages our child may suffer as a result of this request.

Signature of Parent/Guardian_____Date_____

****This form can be faxed directly to the Nurse's Office at 724-775-0578****