School District of Jefferson
Dispensing and Administering Medications to Students

Student Name: ____ Birthdate: _____________________

Male ☐ Female ☐ School: ____

Parent/Guardian Name: ____

Home Phone: _________________________________ Work Phone _________________________________

Physician Name: ____

Physician Address: ____

Physician Phone:______________________________ Physician Fax: _______________________________

To Parent/Guardian/Physician:

The School District of Jefferson is required by state statute to give prescription medication to students only with the complete directions from a physician and signed consent by parent/guardian. Medication must be 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.

Medication: __________________________________ Dosage: _________________ Frequency: _______________

Start Date: ______________________ End Date: _______________________

Form: Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Nebulizer ☐ Injection ☐

For episodic/emergency events only ☐ Other: ____

*Emergency Medications:
(inhaler, glucagons, insulin, epipen) - 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)

Parent/Guardian Signature: ____ Date: ___________________
(Signature required for all prescription and non-prescription medication)

(Please return completed form to your child's school)