Tuscarora School District

School Health Service

Private Health Care Professional's request for Supervision of Self Administration of **Prescription and Non-Prescription medication** during school hours.

Date: ______________________________

Student Name: ______________________________

Diagnosis: ______________________________

Name of Medication: ______________________________

Route: ______________________________

Dosage: ______________________________

Time: ______________________________

Duration of Medication: ______________________________

Possible side effects: ______________________________

Curtail/limitation of normal activities (ex. Sports, shop, driver's ed)

Please specify ______________________________

Is student capable of self-administration: please circle yes no

Health Care Provider's Signature: ______________________________

Health Care Provider's printed name: ______________________________

Phone: ______________________________

I hereby relive the Tuscarora School Board and it's employees of liability for medication administration and grant permission to the Tuscarora School District personnel to administer or supervise the self-administration of the above-mentioned prescription medication/over-the-counter medication, as directed, during school hours to my child.

______________________ ______________________________

Date Parent/Guardian Signature

Parents, If you do have your doctor fax this form to me ______________________ please sign the bottom portion yourself first. Thank you.

Revised August 2015 jb/kf