The Marshall School

REQUEST FOR MEDICATION / TREATMENT DURING SCHOOL HOURS

The Marshall School requires this form to be on file prior to any student receiving medication or prescribed treatments. This form is required for all medication, prescription and over the counter, and treatments to include the use of crutches, wheelchairs and other durable medical equipment and must be renewed yearly.

1. Parent/Guardian or authorized adult must bring in all medications to the school clinic.
2. Medications must be verified, counted, and documented by the school nurse or authorized designee.
3. All prescription medications must be in the original prescription bottle with the pharmacist's label attached.
4. Over the counter (OTC) medication must be in the unopened original container with the manufacturer's dosage label and safety seal intact.
5. The first day's dose of any new non-emergency medication must be given at home before it can be administered at school.
6. Parent/Guardian is responsible for collecting any unused portion of a medication prior to the end of the school year; any unclaimed medication will be destroyed

Medication/Treatment Authorization Order *(to be completed by the healthcare provider)*

Student's Name:_____ DOB:_____

Reason for Medication/Treatment:_____

Medication/Treatment:_____

Dosage:_____ Time(s) to be given at school:_____ Route:_____

Duration: □ School Year □ Short Term (dates required)_____

Special Instructions, Side Effects, Comments:_____

If PRN, specify when indicated (signs/symptoms):_____

I certify that, in my opinion, it is medically necessary that the medication/treatment described above be administered to the named student during school hours and is to be administered by the school nurse or authorized designee.

Physician's Name & Signature:_____

Phone Number:_____ Fax Number:_____ Date:_____

Consent to Administer Medication *(to be completed by the parent or guardian)*

I hereby request and authorize School personnel to administer medication/treatment as ordered by the health care provider, according to the directions provided. I authorize a representative of the school to share information regarding this medication/treatment with the above health care provider and school staff as necessary for the student's health and safety at school. I agree to release, indemnify, and hold harmless The Marshall School and any of its staff members or agents from lawsuit, claim demand, or action against them for administering medication to this student. I understand and agree to comply with the school's policies and procedures as stated on the back of this form and I have discussed this information child.

Parent/Guardian Name:_____ Date:_____

Parent/Guardian Signature:_____