CUSTER SCHOOL DISTRICT 16-1

PERMISSION FOR MEDICATION TO BE DISPENSED AT SCHOOL

Student _____School Year____to_____

School _____Grade _____ Start date: _____ End date: _____

MEDICATION _____

DOSAGE _____ ROUTE _____

DIRECTIONS_____

☐ Over the Counter ☐ Prescription Prescribing Physician _____

- Prescribed medication will be provided in the original container stating the name of the medication, students name, the name of the pharmacy, physicians name, and the dose to be given.
- Over-the-counter medications will be in the original store container and in an age appropriate form and dose.
- "Natural remedies", herbs, vitamins, dietary supplements, and homeopathic medications are considered a prescription medication and require a physician's order.
- Cough medications will be in the original store container. Consents for cough medications will be good for a maximum of 2 weeks.
- The first dose of any medication must be given by the parent/guardian.
- Parent/guardian is responsible to pick up unused medications from school.

I hereby give permission to those duly authorized and trained agents of the Custer School District to dispense the above medication to my child. Furthermore, I specifically indemnify the school system and its employees from any harm, which may occur as a direct result of the administration of the above-cited medication.

Signature of Parent/Guardian_____Date_____