

Johnston Community School District
Johnston, Iowa 50131

MEDICATION RELEASE

STUDENT _____ GRADE/ROOM _____

PHYSICIAN/DENTIST _____ PHONE _____

NAME OF PHARMACY _____

DIAGNOSIS _____

Please give:

MEDICATION _____

AMOUNT _____

TIME _____

STARTING DATE _____ ENDING DATE _____

AMOUNT SENT _____

I request that the prescribed drugs or medication be dispensed according to these written directions. I request that this medication be given by a qualified staff person. The student has experienced no previous side effects from the medication. I further agree that school personnel may contact the prescriber as needed and that medication information may be shared with school personnel who need to know.

I understand the law provides that there shall be no liability for damages as a result of the administration of medication where the person administering the medication acts as an ordinary reasonably prudent person would under the same circumstances and that the school district and the school nurse are to incur no liability, except for gross negligence, as a result of injury arising from the self-administration of medication by the student.

PARENT/GUARDIAN SIGNATURE _____

DATE _____

HOME PHONE# _____ WORK PHONE# _____

MEDICATION WILL NOT BE GIVEN IF IT HAS EXPIRED OR IT HAS AN IMPROPER LABEL. PLEASE CHECK THE CONTAINER BEFORE SENDING IT TO SCHOOL.

SUGGESTION: WHEN YOU PICK UP YOUR CHILD'S PRESCRIPTION, ASK YOUR PHARMACIST FOR A SECOND BOTTLE LABELED FOR SCHOOL.

Johnston Community School District Policy #507.2 Administration of Medications to Students may be accessed by going to the home page www.johnston.k12.ia.us Board of Education, Policies #500