Tri-Valley School District 49-6

"Home of the Mustangs"
46450 252nd Street
Colton, SD 57018-5712
Phone: 446-3538 or 543-5500
Fax: 446-3520

REQUEST AND AUTHORIZATION FOR MEDICATION

Name of Student____

Address ____

Parent's Name ____

**WE ENCOURAGE MEDICATION HOURS BE ARRANGED OUTSIDE OF SCHOOL HOURS AS MUCH AS POSSIBLE.

Physician's Statement (required only if school personnel are to supervise medication at school)

1. Name of medication____
2. Reason for medication____
3. Dosage and time(s) to be administered at school________________________
4. Duration (week, month)____
5. Precautions and reactions to observe and report________________________

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____________________	____________________	_______________
Physician's Signature	Telephone	Date

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Parent's Statement (check one option)

_____1. I request and authorize personnel at the above named school to supervise the medication prescribed on this form to my child. I understand the medication must be provided in a bottle, identifying the name and telephone number of the pharmacy, the student's name, physician's name and dosage of the drug to be given. I understand that the school district and individuals involved will not be held liable for any adverse effects of the medication.

_____2. I authorize my child to take his/her own medication while at school and relieve the school district and personnel of all responsibilities.

____	_________________
Parent's Signature	Date