



Wild Rose Public Schools

AP 317 - Medication/Personal Care Request Form

Name of Child \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Father/Guardian – work phone number \_\_\_\_\_

Mother/Guardian – work phone number \_\_\_\_\_

Name of Medication \_\_\_\_\_

Personal Care Required \_\_\_\_\_

Purpose of Medication/Personal Care \_\_\_\_\_

Name of Doctor\* \_\_\_\_\_ Phone Number \_\_\_\_\_

*\*where procedures beyond a written prescription are required, written instructions from the doctor shall be required*

Time(s) Medication/Personal Care is to be given \_\_\_\_\_

Dosage, frequency, time, and/or related instructions \_\_\_\_\_

Possible Side Effects and appropriate treatment \_\_\_\_\_

Termination Date of Medication/Personal Care \_\_\_\_\_

**Parent's Request and Approval**

I hereby request and give my permission to the above school to administer medication (including Epi-Pen, transportation to hospital for life-threatening allergies) prescribed on this form to my child.

I agree to supply the medication in its original container which identifies the owner and contents. The supply will be replenished when necessary without contact by the school.

We the parents/guardians, hereby waive all rights of action on behalf of ourselves and/or our child in case of any cause of action that may arise as result of the principal/designate proceeding with our request.

\_\_\_\_\_  
Mother/Guardian

\_\_\_\_\_  
Father/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

**School Use**

Person administering Medication/Personal Care: \_\_\_\_\_

Alternate Person: \_\_\_\_\_

Location where Medication/Personal Care supplies are kept: \_\_\_\_\_