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: ______________________