JOHNSTON COMMUNITY SCHOOL DISTRICT
JOHNSTON, IOWA 50131

MEDICATION RELEASE

STUDENT____**AGE**_________**GRADE/ROOM**_________

PHYSICIAN/DENTIST____**PHONE**____________________________

NAME OF
MEDICATION____

NAME OF
PHARMACY____**PHONE**___________________________

DIAGNOSIS____

Please give the above 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#_____________________________________**WORK #**____

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 BOTTLE LABELED FOR SCHOOL USE.

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