Viborg-Hurley School District 60-6
Medication Request Form

Student's Name _____ **Grade** _____

Drug Allergies _____

I request and authorize officials at the Viborg-Hurley School to supervise the administration of the medication listed below. ***(Complete and return this form with registration papers)***

Parents Signature: _____ **Date:** _____

Parents Phone Number: _____

Please follow the guidelines below when bringing medication to school:

1. For student safety, **all medication (including Tylenol, Ibuprofen, Sudafed, etc.) should be brought to the school office by the parent. Controlled substances must be brought to the school office by the parent.**
2. Medications **are not** provided by the school, including Tylenol, Ibuprofen, Sudafed and other over the counter medication.
3. **All medication** must be in its original, properly labeled container with a written request signed by the parent/guardian.
4. Only medication that cannot be given at home will be given at school.
5. Only a 30-day supply of medication will be accepted at a time.
6. **Medication that has expired or is not picked up by the parent will be destroyed.**
7. Authorized district employees may administer medication.
8. Aspirin or products containing aspirin will not be given without a physician order.
9. Students with **food allergies** must have a doctor's note stating the allergy.

Physician's Name: _____ Phone Number: _____
Medication: _____
Dosage: _____ Time: _____ Days to Give: _____
My child has taken this medication before: _____ Yes _____ No
Reason for needing the medication: _____
Expiration Date (Responsibility of the Parent): _____

Any special instructions/precautions/side effects of this medication for your child? _____
_____

_____ I wish to be notified whenever this medication is given.

_____ I DO NOT wish to be notified whenever this medication is given

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By my signature below, I affirm that it is impossible to schedule the above-mentioned medication at a time other than school hours. I request that the medication be given by a school employee. I acknowledge that I will not hold the Viborg-Hurley School and/or District employees for damages or injuries resulting from administration of this medication (prescription/nonprescription/homeopathic/over-the-counter), dietary supplement and/or herbal supplement including cough drops and throat lozenges.

I consent to the release of the medical information contained on this form to school officials who have a legitimate educational interest in the information. I give permission for the release of confidential information regarding my child's specific health problems to third parties, other than school officials, including the physician and/or physician's office identified below, as required to facilitate medical care and/or treatment of my child.

Parents Signature: _____ **Date:** _____

A physician's signature is required to administer over-the-counter medication for more than 10 consecutive days.

Physician's Signature: _____ **Date:** _____