Request for Administration of Medication by Injection in Emergency Situations

Student:		Address:	
School:		Home Telephone:	
Date of Birth:		Parent's Name:	
Grade:		Business Telephone:	

Physician's Instructions for Administering Medication by Injection

Name of Medication: _____

Dosage: _____

Method of Administration: _____

Symptoms Indicating Emergency: _____

Dates for which authorization applies (length of time medication is given): _____

_____

Possible side effects: _____

Special Storage & Safekeeping requirements (if necessary): _____

Physician's Name		Physician's Signature	
Telephone		Physician's Address	

Parent / Guardian Authorization and Release

I / We hereby request and authorize that the above medication and procedure as outlined by my / our physician and / or as demonstrated by me / us to volunteers (in the presence of the public health nurse) be administered by injection to my / our child, in an emergency.

I/We hereby release the Durham Board of Education, its employees and agents from all manner of actions, causes of action, suits, losses, damages or injuries howsoever caused, by negligence or otherwise, arising out of the administration or failure to administer medication as provided herein, and I/We do also hereby agree to indemnify the Board, its employees or agents for any losses or damages sustained by them as a result of such actions or proceedings being commenced against them by myself/ourselves or my/our child, or any other parent or guardian of said child.

I/We hereby acknowledge that I/we have read and fully understand the terms set our herein.

Parent/Guardian Signature(s)		
Date		

Note: This request will expire June 30 of each year

ADMINISTRATION OF MEDICATION

CHILD MEDICATION LOG

Name of child / pupil: _____

Name of Parent: _____

Home Address: _____

Home Phone: _____ Business Phone: _____

Name of Prescribing Physician: _____

Office address and Phone: _____

DATE	AMOUNT / 1 DOSE OF MEDICATION	TIME GIVEN	STAFF SIGNATURE	COMMENT / OBSERVATION OR REACTION IF SIGNIFICANT