ADMINISTRATIVE REGULATION 5150.0
Procedures for Administration and Recording of Medication
Churchill County School District

REQUEST FOR MEDICATION DURING SCHOOL DAY

The prescribing physician advises you that ________________________________,
(Student Name)

______________, a certified student of the Churchill County School District, attending
(Birthdate)

_______________________ requires the following medication during the school day:
(School)

Name of medication: ____

Dosage of medication: ____

Route of medication: ____

Time medication is to be given: ______________________________________

For school year: __________ Date to start: ___________ Date to end: ___________

This medication will be provided to the Churchill County School District by the student's parent/guardian and the undersigned parent/guardian agrees to assume all responsibility for maintaining the supply of the medication and replacing such medication when its effectiveness has lapsed/expired.

The undersigned parent/guardian hereby requests the Churchill County School District, through Special Services or school staff, to administer the above-described medication as set forth and further consents to the administration of such medication during the school day. The undersigned parent/guardian hereby expressly relieves the Churchill County School District, its Board of Trustees, and all agents of the District from any liability for the administration of such medication.

________________________________ ________________
Signature of Prescribing Physician Phone

________________________________ ________________ __________________
Parent/Guardian Signature Date Phone

REVIEWED BY:

________________________________ ________________ __________________
Registered Nurse/Licensed Practical Nurse Date School

CCSD Form 1M