Ramapo Indian Hills High School District

MEDICATION FORM

HAVE DOCTOR FILL IN REQUIRED SECTIONS. PARENTS SIGN FORM AND RETURN COMPLETED FORM TO THE NURSES OFFICE.

STUDENTS NAME: _____ **Grade:** _____
DATE OF BIRTH: _____ **HOME PHONE:** _____

The following medication may be administered to my patient _____

DIAGNOSIS: _____ **MEDICATION:** _____

DOSAGE/ROUTE: _____ **TIME TO BE GIVEN:** _____

SIGNIFICANT SIDE EFFECTS: _____
_____

Tylenol (acetaminophen) 325 mg: _____ **How many:** _____
How frequently: _____ **PRN:** _____

Advil / Motrin (ibuprofen) 200 mg: _____ **How many:** _____
How frequently: _____ **PRN:** _____

Cough drops: _____ **How many:** _____
Tums: _____ **How many:** _____
Pepto Bismol: _____ **How many:** _____
How frequently: _____ **PRN:** _____

Medication taken at home YES: _____ **NO:** _____
Name of Medication:
_____
_____

MD NAME (print): _____
MD STAMP:
MD SIGNATURE: _____

I request for my child, _____**, to receive medication as designated above. I have been informed that the school district, its agents, and employees shall incur no liability whatsoever as a result of any untoward reaction arising from the administration of medication to my child. I hereby indemnify and hold harmless the Ramapo Indian Hills Board of Education, its agents, and employees from any and all claims.**

DATE: _____ **PARENT SIGNATURE:** _____