CARSON CITY SCHOOL DISTRICT
Health Services Department
P.O. Box 603
Carson City, Nevada 89702

MEDICATION TO BE GIVEN AT SCHOOL: SIGNED APPROVAL

Student: _____ Grade: _____ School: _____ Age: _____

Medication Name	Directions for Administration	Time Due

ANY MEDICATION ALLERGIES: _____

The law allows any person (not necessarily a nurse) to assist in carrying out a physician's recommendations and the school recognized the desirability of responding to the physician's request. This accommodation on the part of the school is not legally required. There, the person signing this form is agreeing to hold the school and its personnel FREE from any or all suits which might arise from these arrangements.

***Student to bring in their own small bottle of Tylenol or Ibuprofen.**

IMPORTANT

Non-Prescription Medications need only signed consent of parent/guardian.

Prescription Medications:

1. If medication is to be given for less than two weeks, the original prescription container (with name of child, medication, special instructions and physician's name) will be accepted with signed consent of parent/guardian.
2. If medication is to be given for more than two weeks or on an as-needed basis, signed permission from parent/ guardian and from the physician requesting the school district to comply with the written medication orders is required. This must be dated the current school year.

By signing this form, I am wishing my Student to take the above named medications at school.

_____ _____ _____ _____
Signature of Parent/Guardian Address Phone Date

***TO BE COMPLETED BY PHYSICIAN FOR PRESCRIPTION MEDICATION ONLY**

Physician's Diagnosis/Indication for medication _____
Precautions, if any: _____
IMPORTANT: Please discontinue this request as of this date _____. (After this date, a new form must be completed for changes/new orders.)

_____ _____ _____ _____
Signature of Physician Address Phone Date

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