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To inspire, empower, and prepare our students for their best future.

PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

Student's Name: ______________________________ Date of Birth: ____________________

Address: ____
Street City State Zip

Parent/Guardian's Name: ____________________________ Phone: ____________________

Physician's name: ____________________________ Physician's phone: ____________________

PHYSICIAN - PLEASE COMPLETE:

The above-named student is under my care and should receive:

Name of Drug: ____________________________ Dose: ______________ Times: ______________

Reason for drug to be administered at school: ____

Beginning date of request: ____________________ Expiration date of request: ____________________

Special instructions for administration: ____

Side effects to watch for: ____

____
Physician's Signature Date

PARENT/GUARDIAN - PLEASE COMPLETE:

PARENT'S PERMISSION FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

I hereby request and give my permission to the principal or a designee (nurse, secretary, teacher, or other responsible trained person) to administer the following medication to my child:

Name of Drug: ____________________________ Dose: ______________ Times: ______________

Reason for drug to be administered at school: ____

Beginning date of request: ____________________ Expiration date of request: ____________________

____
Parent/Guardian's Signature Date

Parents MUST send medication to school in its original container.

Note: The parent/guardian of the child must assume responsibility for informing the principal and school nurse of any change in the child's health or any change in the prescribed medication. Any change to the above prescription (dosage or administration) will require the completion of a new form.

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School Official's Signature (Acknowledging Receipt) Date