Parent / Guardian Request for Administration of Medication by School Personnel

Student Name: ____________________________ Grade: _______

Allergies: ____________________________________________

Name of Medication: ____________________________ Amount: ____________________________

Date / Time to start medication: ______________ Date / Time to stop: ______________

Special instructions / side affects / adverse reactions / storage requirements: ____________________________

______________________________  ____________________________
Physician's name: ____________________________ Phone #: ____________________________

I hereby request and give permission to the school nurse or other authorized person to administer
the above medication to my child. I understand the following:

a. All medication must be in its original container
b. Any revision to the above medication requires a new form to be completed and signed. This request is valid for one school year.
c. It is the student's responsibility to come to the school clinic for the medication unless he/she is physically unable to do so.

______________________________  ____________________________
Parent / Guardian signature: ____________________________ Date: ______________

Phone #: (H) ____________________________ (W) ____________________________ (C) ____________________________

Medication Administered by 1. ____________________________ Initials: ____________________________

2. ____________________________ Initials: ____________________________