



Developmental Research School
at the University of Florida

Request for Administration of Medication by School Personnel

Student's Name: _____ Grade: _____

Allergies: _____

Name of Medication: _____ Amount: _____

Special Instructions/side effects/adverse reactions/storage requirements: _____

Physicians 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's (Guardian's) Signature: _____ Date: _____

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

Medication Administered by 1: _____ Initials: _____

2: _____ Initials: _____
