Request for Administration of Medication by School Personnel

PK Yonge
Developmental Research School
at the University of Florida

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:_____

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