Request for Administration of Medication by School Personnel

Developmental Research School
at the University of Florida

Student Name: ____________________ Grade: __________

Allergies: ______________________________

Name of Medication: ____________________ Amount: __________

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

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Physician 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) Students are responsible for coming to the clinic for the medication unless physically unable to do so.

Parent/Guardian Signature: ____________________ Date: __________

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

Medication Administered by 1: ____________________ Initials: __________

2: ____________________ Initials: __________

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