

**PARENT'S REQUEST FOR MEDICATION ADMINISTRATION BY SCHOOL PERSONNEL**

I request that medication be administered to my child, \_\_\_\_\_ Grade \_\_\_\_\_

In accordance with the instructions of our physician, Dr. \_\_\_\_\_.

I understand that there may not be a nurse in the building to dispense the medication.

It is the parent's/legal guardian's responsibility to provide the school with an adequate supply of medication. It is preferred that the medication be brought to the school office daily, however, no more than one week's supply should be provided at one time unless prior arrangements have been made with the nurse or principal. An exception to this would be emergency supplies for allergies or diabetics.

For each prescribed medication, the container shall have the original Pharmacist's label listing: the student's name, the physician's name, the date, pharmacy name and telephone number, the name of the medication, prescribed dosage, frequency and special handling or storage instructions.

I agree to notify the school immediately if:

- 1. I change physicians
- 2. The medication or dosage has changed
- 3. The administration of the medication is to be terminated.

Date: \_\_\_\_\_ Signature of Parent or Guardian: \_\_\_\_\_

**THE REMAINDER OF THE FORM MUST BE COMPLETED AND SIGNED BY A PHYSICIAN**

\_\_\_\_\_ is under my care and should receive \_\_\_\_\_  
Name of Student Name of Drug

\_\_\_\_\_ at the following time \_\_\_\_\_  
Dosage, Route

My specific instructions for administration are: \_\_\_\_\_

Possible side effects to watch for: \_\_\_\_\_

Expiration date for this request: \_\_\_\_\_

Physician's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Address: \_\_\_\_\_ Phone: \_\_\_\_\_