PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

_____ is under my care and should receive
Name of Student

_____ at the following times _____
Name of Drug, Dosage, Route

Diagnosis requiring this medication: _____

Specific instructions for administration: _____

Possible side effects to watch for: _____

Expiration date of this request: _____

Date _____ _____
Physician's Signature

_____
Physician's Phone Number

MEDICATION MUST BE IN ORIGINAL CONTAINER

PARENT'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

I hereby request and give my permission to the school nurse (Principal or other responsible person) to administer the following medication to my child.

Name of Child _____

Name of Drug _____ Dosage _____ Route _____

At the following time(s) _____

Date _____ _____
Signature of Parent or Guardian