



Parent/Physician Request to Administer Medication at School

Student name: \_\_\_\_\_ Date: \_\_\_\_\_

Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

- In accordance with Diocesan policy, only medication that is necessary for a child to remain in class will be given during school hours.
- Prescription medication must have a pharmacy label.
- Over-the-Counter medications must be in the original packaging and physician's signature is required to administer OTC meds for more than 10 consecutive school days from the date of the original request.
- Students receiving asthma medication must have an Asthma Action Plan on file. They may keep a rescue inhaler with them with a Dr's order on file.

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

At the following time(s): \_\_\_\_\_

On the following date(s): \_\_\_\_\_

Has your child had a dose of this medication before?  
(Please circle) YES NO

Condition for which medication is required \_\_\_\_\_

Special instructions/side effects: \_\_\_\_\_

This medication may remain at school: (Please circle) YES NO

Parent/Guardian signature: \_\_\_\_\_ Daytime phone \_\_\_\_\_

Physician name: \_\_\_\_\_ Signature \_\_\_\_\_ Phone \_\_\_\_\_