REQUEST FOR ADMINISTERING MEDICATION AT SCHOOL

THIS FORM IS DESIGNED TO ASSIST IN OBTAINING REQUIRED INFORMATION FROM YOUR DOCTOR, OR OTHER MEDICAL PERSONNEL AS STATED IN THE LAW. WITHOUT COMPLETED FORM ON FILE, MEDICATION WILL NOT BE ADMINISTERED TO YOUR CHILD BY ANY SCHOOL PERSONNEL.

Student Name ____ Grade ______________________

Medication ____

Method____

Reason for taking Medication ____

Dosage ____________________________ Time of day to be administered _______________________

Special Instructions ____

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Physician Name_________________________________ Physician Phone __________________________

Physician Signature ____

I understand that prescription medication must be provided in the labeled prescription bottle with the child's name on it. If the medication is an over-the-counter medication, it must be in the original container and have the child's name written on the container. I also understand that school personnel may contact the doctor regarding administration of this medication. I understand this medication may be administered by someone other than a licensed nurse who has been appointed to do so by the school administrator.

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Parent/Guardian Signature Date