



Request for Administration of Medication at School

Student's Name _____ **DOB** _____

Address _____ **Phone** _____

Dear Parent/Guardian:

Every effort should be made to administer medication at home, as it does represent a disruption in the student's school day. However, if your physician feels that it is necessary, please submit this completed form before medication is sent to school. A new form must be filled out for each change in medication and renewed each school year. Prescription medication to be administered for ten (10) days or more must have a request for administration of medication during the school day signed by the student's physician and parent on file in the school office.

TO BE COMPLETED BY PARENT/GUARDIAN:

I request the principal, school secretary, or designee, to direct and designate the administration of medication as prescribed below by my child's physician to my child.

Child's Name _____ **Date** _____

**Parent/Guardian
Signature** _____ **Relationship** _____

TO BE COMPLETED BY PHYSICIAN:

Student's Name _____

Diagnosis _____

Name of Medication(s) _____

Dosage: (Please Include Amount to be given, times to be given and how often daily)

Side Effects: To report _____

To expect _____

Additional Comments _____

Physician's Name _____ **Date** _____

Physician's signature _____ **Phone** _____

Teacher _____

Grade level _____