Request for Administration of Medication at School

Use this form when medication must be administered for more than ten (10) days or more. Use "Parental Authorization to Administer Medication" for less than ten days.

Student's Name: ____ DOB: ____________

Address: ____ Phone: ________________________

Grade: __________________ Teacher: ____

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 brought to school. A new form must be filled out for each change in medication and renewed each school year. School policy does not permit daily administration for longer than ten (10) days without written directions from the physician and parent.

♦♦

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.

Parent/Guardian Signature ________________________________ Date_______________

Relationship____

♦♦

TO BE COMPLETED AND SIGNED BY PHYSICIAN:

Student's Name: ____

Diagnosis: ____

Name of Medication(s)____

Dosage — **Amount to be given: _______________________________________**

Time to be given: ____

Side Effects — **To report: ____**

To expect: ____

Additional Comments: ____

Physician's Name: ____ Date: _________________

Physician's Signature:_____________________________________ Phone: __________________

20140808