Physician's Request for the Administration of Medication by School Personnel

Student Name: _____ Date of Birth: _____

School: _____ Grade: _____

Parent Section

Please review the following steps required for permission of school personnel to administer any medication to your child and sign this section:

1. This form must be completed by both the parent (top section) and physician (bottom section).
2. Medications must be kept in the student's prescription labeled bottle. (Pharmacy may provide an extra bottle for long-term medication.) Prescription label must match instruction from the doctor. If it is non-prescription drug, it must be in the original container.
3. A revised statement signed by the physician must be provided when there is a change in the dosage to be given and a new form provided each school year.

When possible, give medication outside of school hours. For example, to be to be able to administer four (4) doses to a child, it might be given before school, immediately after school, around dinner, and directly before bed. Please contact the school nurse if you have questions.

Parent/Guardian Signature:_____ Date:_____

Parent/Guardian printed name: _____ Phone:_____

Physician Section

I, the undersigned physician, am certifying that medication for the student listed below cannot be scheduled for other that school hours. Further, I realize that medically untrained personnel may supervise the administration of such medication.

I verify that this medication must be taken by: _____
Name of Student

Name of Medication: _____Dosage to be Administered: _____

# of pills supplied: _____

Possible severe reactions/side effects that should be reported to the doctor: _____

_____

Special instructions for administering the medication, including storage requirements or sterile conditions:

_____

Time medication is to be taken: _____Prescription start date:_____ Expiration date:_____

Physician's Signature: _____ Date:_____

Physician's printed name: _____Phone: _____

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