



Request for Administration of Medication at School



A. Student Information:

Student: _____ DOB: _____ Grade: _____

Parent/Guardian Name: _____ Phone #: _____

B. Parent/Guardian Approval

I hereby request and give permission to _____ to administer oral
(Name of Teacher)

medication to my child according to the detailed instructions noted below:

Parent/Guardian's Signature Date

C. Physician's Instructions:

Name of Medication: _____

Instructions:

Dosage of Medication: _____ For how many days? _____

How often is it to be given? _____ At what times? _____

Additional Information re: Administration of medication: _____

Possible side effects: _____

Action to be taken in the event of the side effects: _____

D. Prescribing Physician's Information:

Physician Name: _____

Address: _____ Phone #: _____

(over →)

E. School Arrangements:

This medication will be kept _____ . It will be administered by _____ or by _____ according to the instructions given.

Dear Parent/Guardian:

You have requested your son/daughter to be given medication while at school. Medication that is essential for school staff to give during school hours will be given once the following steps have been taken. These steps are for the safety of your child.

1. Parts A, B, C, and D of the form "Request for Administration of Medication at School" (*on reverse*) are completed and the form has been returned to the main office.
2. School staff has the information needed to safely give the medication to your child.
3. Medication is at school in the original container from the pharmacy.

Please notify the school of changes to medication. When there are changes it may be necessary to have a new form completed for administration of medication.

Principal's Signature

Date