Student Name: _____

Grade: _____ Teacher: _____

School: _____

School Phone: _____

School Fax: _____

REQUEST FOR ADMINISTRATION OF MEDICATION TO STUDENT

Dear Parent/Guardian:

Under certain conditions, as service to you and for the welfare of your child, parental requests for the in-school administration of necessary prescribed and/or over-the-counter medication/health procedures will be honored. This request is filled out individually for each medication required to be given during school hours and renewed at least annually. This parental request also gives the school permission to contact the prescribing provider as necessary. **Please note**: "Medication" refers to any prescription, non-prescription, homeopathic, herbal, vitamin, or mineral preparation.

Medications MUST:

◍ Be in original pharmacy container ◍ Brought to school by parent/guardian,other responsible adult,or the pharmacy

Medications MUST have a label showing the following:

◍ Student's Name ◍ Name of medication ◍ Dosage ◍ Frequency ◍ Doctor's Name ◍ Pharmacy Name ◍ Date Issued ◍ Prescription Number ◍ Expiration Date

The written statement below, signed and dated by the attending physician, supporting this signed parental request is required prior to medication being given. The physician's statement must also provide clear direction for administering the medication or health procedure in school. If the medication must be given at a certain time per the physician orders, the staff has a 30 minute window before and after the ordered time to administer the medication.

PARENT

As indicated by the prescribing physician below, I do hereby request and authorize that the prescribed or over-the-counter medication/health procedure be administered to:

Student Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Parent/Guardian Name (printed): _____

Parent/Guardian Signature: _____ Date: _____

****I understand it is my responsibility to notify the school of any change or discontinuation of the medication(s)****

PHYSICIAN

I recommend that the prescribed or over-the-counter medication/health procedure listed below be administered to:

Student Name: _____ Date of Birth: _____

Diagnosis: _____

Name of Medication/Health Procedure: _____

Dosage: _____ Time/Frequency: _____

Give Medication **Before Lunch:** yes/no **After Lunch:** yes/no

Route of Administration: _____

First Date of Administration: _____ Last Date of Administration: _____

Additional Directions/Precautions (please note reason to administer if PRN dose): _____

_____

Physician Address: _____

Physician Phone Number: _____

Physician Name (printed): _____

Physician Signature: _____ Date: _____

Imprint Physician Office Stamp Below: