**PHYSICIAN’S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL**

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:

Physician’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHYSICIAN - PLEASE COMPLETE:**

The above named student is under my care and should receive:

Name of Drug: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_Times:\_\_\_\_\_\_\_\_\_\_\_\_

Reason for drug to be administered at school:

Beginning date of request:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration date of this request:

Special instructions for administration:

Side effects to watch for:

Physician’s Signature Phone Date

**Parent must indicate that student is allowed to self-carry their Emergency Medication and Supplies**

**□** I authorize and recommend self-medication by my child for the prescribed listed medication

Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ I also affirm that my child has been instructed in the proper self-administration of the prescribed medication by their attending prescriber

Parent/Guardian’s Signature Date

**PARENT/GUARDIAN - PLEASE COMPLETE:**

**PARENT’S PERMISSION FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL**

I hereby request and give my permission to the principal or a designee (nurse, secretary, teacher, or other responsible person) to administer the above named medication to my child by the above named physician as it is prescribed:

Parent/Guardian’s Signature Phone Date

**Parents MUST send medication to school in it’s original container.**

Note: The parent/guardian of the child must assume responsibility for informing the Principal and school nurse of any change in the child’s health or any change in the prescribed medication. Any change to the above prescription (dosage or administration) will require the completion of a new form.

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