



## Request to Administer Medication Form

If you wish your child to be given medication at school, we need the following information. The Purpose is to make sure that your child receives the prescribed medication and that school personnel know the expected reactions to the medication. Please send medication to school, in the original container, with the prescription label attached, It is the responsibility of the parent to submit a new form if the medication is changed on any way (such as time, route, dosage, or if discontinued).

*Medications that contain narcotics WILL NOT be given during school hours. Students may carry certain medication as ordered by the doctors and with the Principal's permission.*

During school hours it is my understanding that trained school personnel will administer the prescribed medication according to the specified physician's recommendations. Should the need arise; I give permission for the school to contact the physician regarding this medication and or the condition for which it is being administered.

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### *To Be Completed By Parent/Guardian*

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

Address: \_\_\_\_\_

Parent/Guardian's Signature: \_\_\_\_\_

Date of Signature: \_\_\_\_\_ Phone No.: \_\_\_\_\_

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### *To Be Completed by The Child's Physician*

Name of Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Time(s) Administered: \_\_\_\_\_

Reason to be Given: \_\_\_\_\_

Possible Side Effects: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Physician's Address: \_\_\_\_\_