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MEDICATION ADMINISTRATION REQUEST

Student's Name____

Grade______________ Date of Birth___________________ Teacher/Homeroom_____________

TO BE FILLED OUT BY HEALTHCARE PROVIDER:

Please administer the following medication to the above-named student as prescribed below:

Medication____ Dosage_______________________

Time to be Administered____

Start Date________________________________ Stop Date_________________________________

Diagnosis____

Possible Side Effects____

If PRN, for signs and symptoms____

Healthcare Provider Stamp below:

____
Signature of Healthcare Provider

Date Effective___________________

TO BE FILLED OUT BY PARENT/GUARDIAN:

_______My child **is** to receive the prescribed medication on "half days".
_______My child **is not** to receive the prescribed medication on "half days".

I request that the above medication be administered to my child.

____ Date________________________
Signature of Parent/Guardian

This completed form, along with the medication, must be hand delivered to the school nurse by the parent/guardian. For safety and the prevention of errors, pupils may not carry medication with them during the school day. The medication must be in the original container and labeled by the pharmacy or medical provider if it is a prescription medication.

REQUESTS ARE EFFECTIVE FOR ONE SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY