REQUEST FOR ADMINISTRATION OF PRESCRIBED MEDICATION AT SCHOOL

A. TO BE COMPLETED BY PARENT OR GUARDIAN

STUDENT'S NAME	BIRTHDATE (YEAR, MONTH, DAY)	
PARENT OR GUARDIAN	HOME PHONE	BUSINESS PHONE
PHYSICIAN	PHONE	

B. TO BE COMPLETED BY PRESCRIBING PHYSICIAN

CONDITIONS (WHICH MAKE MEDICATION NECESSARY)

NAME OF MEDICATION	DOSAGE	DIRECTIONS FOR USE
1.		
2.		
3.		
4.		

ADDITIONAL COMMENTS, POSSIBLE REACTIONS, CONSEQUENCES OF MISSING MEDICATION, ETC.

_____
PHYSICIAN'S SIGNATURE

_____
DATE

C. TO BE COMPLETED BY PARENT OR GUARDIAN

I REQUEST THE SCHOOL TO GIVE MEDICATION AS PRESCRIBED ON THIS FORM TO MY CHILD WHOSE NAME IS RECORDED BELOW

_____
NAME OF CHILD

I WILL NOTIFY THE SCHOOL PROMPTLY OF ANY CHANGES IN MEDICATIONS ORDERED

_____
SIGNATURE OF PARENT OR GUARDIAN

_____
DATE

D. CONSULTATION (AS NEEDED) WITH COMMUNITY HEALTH NURSE AFTER THE COMPLETED REQUEST IS RETURNED TO THE SCHOOL AT REQUEST OF SCHOOL ADMINISTRATION

COMMENTS

_____ _____
COMMUNITY HEALTH NURSE SIGNATURE DATE

SUBSEQUENT COMMENTS, IF ANY:

_____ _____
SCHOOL ADMINISTRATOR DATE

E. EACH SCHOOL STAFF MEMBER WHO IS RESPONSIBLE FOR THE ADMINISTRATION OF THE MEDICATION MUST REVIEW THE INFORMATION ON THIS CARD THEN DATE AND SIGN BELOW.

DATE	SIGNATURE	COMMENTS, IF ANY

This request form must be reviewed annually and/or as changes to medications occur.