



**REQUEST FOR ADMINISTRATION OF
PRESCRIPTION MEDICATION DURING THE SCHOOL DAY**

Parents of pupils requesting that medication be administered during school hours by school staff are required to provide for the school: 1) the physician order, 2) a parental release, and 3) medication supplies in the original bottle.

Pupil's name: _____ Date of Birth: _____

Home Address: _____

School: _____ Grade: _____ Homeroom: _____

Physician's order for administration of medication by school personnel.

I have prescribed the following medication for this child and request the dosages be given during school hours:

Medication: _____ Dose & Time: _____

For treatment of: _____

Possible side effects: _____

Special instructions: _____

Last date to be given: _____

Our clinic would like the following information: _____ by (date) _____

Physician's signature: _____ Phone: _____ Date: _____

Print physician's name & address: _____

Parental request for administration of medication and release of information.

Only when a medication is prescribed to be taken during school hours will a child be given medication at school. I request this medication be given as prescribed and the above requested information be released to the physician from the school. If necessary the school may request additional information from the physician regarding this illness.

Parent/Guardian signature: _____ Daytime phone: _____ Date: _____