# JACKSON-MILTON LOCAL SCHOOLS
# REQUEST FOR ADMINISTRATION OF MEDICATION

BUILDING: ______________________________

***Physician's Request** for the Administration of Medication by School Personnel:*

Student's Name: ______________________________

Address: ______________________________

Phone: ____________________ Grade Level: ________

The above listed student is under my care and should receive the following medication according to the following instructions:

a. Name of medication ______________________________

b. Dosage ______________________________

c. Time to be administered ______________________________

d. Duration of medication ______________________________

e. Purpose of medication ______________________________

f. Possible side effects ______________________________

g. Termination date for administering medication ______________________________

h. Special instructions or comments ______________________________

DATE: ____________________

______________________________
Physician's Stamp & Signature

______________________________
Physician's Phone Number (s)

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***Parent's Request** for the Administration of Medication by School Personnel:*

I hereby request and give my permission to the principal and his designee to administer the above described oral medication to my child, ______________________________ at school according to school district policy and as instructed by the physician and agree to:

- Assume responsibility for safe delivery of the medication to the school
- Have a new form completed by the physician if medication or dosage is changed
- Notify the school if we change physicians

I give permission for the school to contact the physician's office regarding the medication should this be necessary.

Parent/Guardian Signature ______________________________ Date ____________________

Daytime Phone Number ______________________________

(8/2000)