New Albany Plain Local Schools

PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

Name of Student_____ Grade_____
Address_____

The above mentioned student is under my care for (diagnosis): _____

And should receive_____

Name of drug, dosage, route

at the following time(s)_____

Administration to begin_____Administration to end_____

Specific instructions for administration: _____

_____

Possible side effects: _____
Name of Physician:_____
Address/Phone: _____

Signature of Physician: _____ Date:_____

PARENT'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

I hereby request and give my permission to the principal or his delegate (school nurse or other responsible person) to administer the following medication to my child. I agree to deliver the medicine to the school in the container in which it was dispensed by the prescribing physician or licensed pharmacist. I grant permission for the school nurse to confer with the above licensed prescriber regarding my child's health and treatment issues as they pertain to the above medication/diagnosis and his/her educational and behavioral management needs. If the above information changes, I will submit a revised statement signed by the physician.

Name of Student: _____
Name of Drug: _____ Dosage:_____ Route: _____
at the following time(s)_____

Signature Parent/Guardian _____Date: _____

Please fax back to New Albany Plain Local School Clinic Attn: School Nurse

Early Learning Center (PreK- K): Fax 413-8701; Phone 413-8706
Primary School (1-3): Fax 413-8601; Phone 413-8608
Intermediate School (4-6): Fax 741-3001; Phone 741-3007
Middle School (7-8): Fax 413-8511; Phone 413-8512
High School: Fax 413-8301; Phone 413-8317

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