St. Ursula Academy
4025 Indian Road Toledo, Ohio 43606
Since 1854

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

Student's Name: _____ Date: _____

The above named student is under my care and should receive:

Name of Drug: _____ Time of Day: _____

Dosage: _____ Begin Date of this Request: _____

Route: _____ Expiration Date of this Request: _____

Please provide instructions for administration:

_____

Please list possible side effects:

_____

Physician's Printed Name: _____

Physician's Signature: _____

Physician's Phone Number: _____

Parent/Guardian Request for the Administration of Medication by School Personnel

Student's Name: _____ Date: _____

I hereby request and give my permission to the Principal or her delegate (school nurse or other responsible person) to administer the following medication to my child:

Name of Drug: _____ Route: _____

Dosage: _____ Time of Day: _____

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____

Parent/Guardian Phone Number: _____