PINE HILL PUBLIC SCHOOLS
Central Administration
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PHYSICIAN'S REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student's name _____ Grade _____ Date _____

Medication _____ Dosage _____

Time to be given _____ Route _____

Purpose of medication _____

Time frame for medication: From _____ to _____

If medication is given on a daily basis, should it be given on a half day?

Yes, give on half days _____ No, do not give on half days _____

May student be excused from the school-time dose if on a field trip? Yes____ No ____

If a parent/guardian occasionally misses the AM dose at home, is the school nurse granted permission to administer the above named medication as prescribed below upon the student's arrival to school and with parent consent?

Yes _____ No _____ AM dosage _____

Signature of physician _____Phone Number _____

Name of physician (printed or office stamp) _____

Additional information _____

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Parent's Request for Administration of Medication at School

I request the school authorities to allow my child _____to receive the above medication as prescribed by Dr. _____. I will furnish the medication in the original pharmacy container with the child's name, medication name, dose, time, and formal written order to administer the medication. I understand that I, or another adult that I designate, will bring the medication to school. I understand that students are not permitted to transport any medications to or from school, or during school hours.

Parent's Signature _____ Date _____

Home Phone _____Cell Phone _____Work Phone _____