

MEDICATION REQUEST

Student's Name: _____

Parent's Name(s): _____

School: _____

School Year: _____

I am unable to come to school to administer medication to my child. Please have school personnel assist me in this matter by administering medication to the above-named child per physician approved directions below. I understand that it is the responsibility of my child to report to the office at the times medication is to be given.

The above named student is authorized to self-administer his/her medication during school hours. It is the physician's and parent's opinion that the student is competent to safely self-administer the medication according to the conditions below.

Name of medication: _____

Dosage: _____

Time medication is to be given: _____ **a.m.** _____ **p.m.**

Dates medication is to be given: _____ **through** _____

Condition for which the medicine is prescribed _____

Adverse effects: _____

Other comments/directions: _____

Physician's Signature _____ Date: _____

I hereby authorize student and school personnel to administer the medication as described above.

Parent's Signature: _____ Date: _____