

Napoleon Area City Schools

PHYSICIAN'S REQUEST - ADMINISTRATION of MEDICATION by SCHOOL PERSONNEL

_____ at
Name of Student _____ DOB _____ Grade _____

_____ is under my care and should receive the following med:
School _____

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

Special Instructions for administration, i.e., sterile conditions, storage, etc:

Possible side effects that should be reported to the physician:

Medication starting date _____ Expiration date of request _____

Date _____ Physician's Signature _____

Phone # _____ Fax # _____

PARENT'S REQUEST - ADMINISTRATION of MEDICATION by SCHOOL PERSONNEL

I hereby request and give my permission to the school nursing personnel or trained designee to administer the above described medication to my child as set forth above. I agree to submit to the school nurse or principal a revised statement signed by the child's physician if any of the information provided by the physician as set forth above changes.

Name of Child _____ Grade/Teacher _____

Name of Drug: _____ Dosage: _____ Route: _____ Time: _____

Date _____ Parent/Guardian Signature _____

Verbal Consent Received (OVER THE COUNTER MEDICATIONS ONLY)

Copy of verbal consent sent home

Consent Received by: _____ Title _____ Date _____

Consent Received from: _____ Relationship to Student _____