REQUEST FOR ADMINISTRATION OF PRESCRIPTION MEDICATION IN SCHOOL 2024-2025

Please complete form in ink

Student's Name:____ Grade:______________________________

Address:____ Home Phone:________________________

PARENT'S REQUEST AND AUTHORIZATION

I, the undersigned, request and authorize the school Health Care Coordinator/staff to administer/store medication as prescribed by my child's physician. I request and authorize release of information between the Health Care Coordinator and the prescribing physician pertinent to the child's condition. I understand that a new request is to be processed should there be any change in medication or physician's orders.

Parent/Guardian's Name:___________________________________ Parent/Guardian's Signature:________________________________Date:_____________

PHYSICIAN'S REQUEST

Diagnosis:____

MEDICATION ORDER (Name and Dosage)	TIME TO BE GIVEN IN SCHOOL	METHOD OF ADMINISTRATION	POTENTIAL ADVERSE REACTIONS

Disposition of student following administration of medication (rest, return to class, etc.):________________________________

Medication to be discontinued on:____

PHYSICIAN'S NAME:____________________________________ PHYSICIAN'S SIGNATURE:______________________________________

ADDRESS:____

TELEPHONE:_________________________________ DATE:____