



# School Health Services

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Middle School

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High School

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## SCHOOL REQUEST FOR ADMINISTRATION OF MEDICATION

Instructions: This form must be completed and signed by the child's physician and parent(s)/guardian and returned to the school before the medications can be administered form must be completed for each medication to be given. All medication received by the school must be in pharmacy packaging, and be delivered to the school by an adult. Medication must NEVER be sent in a student's book bag.

### TO THE PHYSICIAN:

Patients Name: \_\_\_\_\_

Date of Birth \_\_\_\_\_ School \_\_\_\_\_

Diagnosis \_\_\_\_\_

Medication \_\_\_\_\_

Required/Dosage/Duration \_\_\_\_\_

Instructions for Administration \_\_\_\_\_

Special Conditions to Observe \_\_\_\_\_ Indicate other medication child is receiving \_\_\_\_\_

Physician's Name \_\_\_\_\_ Physician Signature \_\_\_\_\_

Address \_\_\_\_\_ Date \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Phone \_\_\_\_\_

### TO THE PARENT

I authorize the school staff to administer the above medication. I authorize the school nurse to communicate with the prescribing physician.

Signature of Parent(s)/Guardian \_\_\_\_\_

Date \_\_\_\_\_ Phone \_\_\_\_\_

### FOR SCHOOL HEALTH SERVICES ONLY

Signature of the School Nurse \_\_\_\_\_ Date Recieved \_\_\_\_\_