



**REQUEST FOR ADMINISTRATION OF
PRESCRIPTION MEDICATION IN SCHOOL
2025-2026**

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: _____