

ROCHESTER AREA SCHOOL DISTRICT  
PRIVATE PHYSICIAN REQUEST FOR ADMINISTRATION OF MEDICATION  
DURING SCHOOL HOURS

It is our procedure to request that medication be given before or after school hours whenever possible. If it is essential that the students receive the medication(s) during school hours, please complete the following information.

Student Name \_\_\_\_\_ Grade \_\_\_\_\_

Name of Medication(s) \_\_\_\_\_

Purpose of Medication(s) \_\_\_\_\_

Dosage \_\_\_\_\_

Time schedule for administering medicine \_\_\_\_\_

Duration of medication administration \_\_\_\_\_

Possible SIDE EFFECTS or contraindications \_\_\_\_\_

Procedure to follow if reaction should occur \_\_\_\_\_

Curtailment of specific school activity (sports, shop, lab, etc...) \_\_\_\_\_

Other medications that student is taking OUTSIDE OF SCHOOL HOURS \_\_\_\_\_

Is STUDENT capable of SELF-ADMINISTRATION \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Physician's Name \_\_\_\_\_ Physician's Telephone # \_\_\_\_\_

I hereby authorize the medication listed above to be administered to my child by the school nurse or other designated person. I release the Rochester Area School District and all its employees for any and all liability for damages our child may suffer as a result of this request.

Signature of  
Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**\*\*This form can be faxed directly to the Nurse's Office at 724-775-0578\*\***

