** MEDICATION REQUESTS**

Medication to be administered during the 20_____-20_____ school year.

NAME: _____ **DOB:** _____ **GRADE**: _____

PHYSICIAN MEDICATION REQUEST SECTION-To be completed by the DOCTOR ONLY!

Any medication allergies? _____ If yes, please list: _____

Medication #1_____ Medication #2_____

Diagnosis_____ Diagnosis_____

Dosage_____ Dosage_____

Time to Be Administered_____ Time to Be Administered_____

*Adverse reactions that may occur for #1*_____

*Adverse reactions that may occur for #2*_____

Medication #3_____ Medication #4_____

Diagnosis_____ Diagnosis_____

Dosage_____ Dosage _____

Time to Be Administered_____ Time to Be Administered_____

*Adverse reactions that may occur for #3*_____

*Adverse reactions that may occur for #4*_____

_____

NAME OF PHYSICIAN (PRINTED)

_____ _____

SIGNATURE OF PHYSICIAN PHONE NUMBER DATE

OFFICE STAMP HERE

PARENT/GUARDIAN MEDICATION REQUEST SECTION-To be completed by the Parent/Guardian

I hereby give permission for my child to receive medication as prescribed above by my child's physician. I also give permission for the release and exchange of information between the school nurse and my child's physician concerning my child's health and treatment. I understand that all medication must be provided by the parent/ guardian in its original container (prescription bottle or OTC packaging), and that expired medications cannot be accepted.

Date: _____ Parent/Guardian Signature: _____