

Fox Chapel Area School District Parent/Guardian Request to Administer Medication in School

Please complete this form if your child requires medication to be administered during the school day.

Student Information

Student Name: _____

Grade: _____

Teacher/Homeroom: _____

School: _____

Parent/Guardian Authorization

Please administer the prescribed medication to my child according to the physician's instructions below.

As the parent/guardian of _____, I release the Fox Chapel Area School District and its employees from all liability for damages my child may suffer as a result of this request.

Parent/Guardian Signature: _____

Date: _____

Physician's Medication Instructions

The parent/guardian has requested that medication be administered during the school day. If you determine that administration during the school day is medically necessary, please complete the information below.

Medical Information

Diagnosis: _____

Medication: _____

Dosage: _____

Administration Time(s): _____

Self-Administration

Is self-administration with adult supervision permitted?

☐ Yes ☐ No

If yes, provide administration instructions: _____

Possible Side Effects

School Activity Restrictions

Describe any restrictions related to school activities (sports, shop, labs, driver's education, etc.).

Medication Duration

Start Date (MM/DD/YYYY): ____ / ____ / ____

End Date (MM/DD/YYYY): ____ / ____ / ____

Other Medications Taken Outside School Hours

Additional Comments

Physician Information

Physician Signature: _____

Telephone Number: _____

Date: _____