Physician and Parent Request for the
Administration of Medication by School Personnel

Name of Student:_____ Birthdate:_____

Parents: _____ Grade: _____ Teacher:_____

Physical condition for which drug is to be given. (If allergic in nature, please specify what type of reaction and indicate in detail those visible symptoms which would give rise to the necessity of administering the medication.)

_____

_____

Medication: _____

Dosage and method of administration: _____

_____

Possible reactions that need to be reported to a physician:

_____

Disposition of pupil following administration of medication, i.e.: rest, home, hospital, physician's office or return to class:

_____

Date of request: _____

Medication to continue as above until:_____(date)

PHYSICIAN'S SIGNATURE: _____Date:_____

Physician Address: _____ Phone: _____

PRINCIPAL'S SIGNATURE: _____Date:_____

PARENT'S SIGNATURE: _____Date:_____

MEDICATION MUST BE LABELED WITH:

1. NAME OF MEDICATION
2. METHOD OF DOSAGE
3. TIME OF DOSAGE
4. STUDENT'S NAME

Revised 4/2022 hg