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MEDICATION ADMINISTRATION REQUEST

Student's Name _____

Grade _____ Date of Birth _____ Teacher/Homeroom _____

TO BE FILLED OUT BY HEALTHCARE PROVIDER:

Please administer the following medication
to the above-named student as prescribed below:

Medication _____ Dosage _____

Time to be Administered _____

Start Date _____ Stop Date _____

Diagnosis _____

Possible Side Effects _____

If PRN, for signs and symptoms _____

Healthcare Provider Stamp below:

Signature of Healthcare Provider

Date Effective _____

TO BE FILLED OUT BY PARENT/GUARDIAN:

_____ My child **is** to receive the prescribed medication on "half days".
_____ My child **is not** to receive the prescribed medication on "half days".

I request that the above medication be administered to my child.

Signature of Parent/Guardian Date _____

This completed form, along with the medication, must be hand delivered to the school nurse by the parent/guardian. For safety and the prevention of errors, pupils may not carry medication with them during the school day. The medication must be in the original container and labeled by the pharmacy or medical provider if it is a prescription medication.

REQUESTS ARE EFFECTIVE FOR ONE SCHOOL YEAR ONLY AND MUST BE
RENEWED ANNUALLY