THIS FORM MUST BE COMPLETED AT THE START OF EACH SCHOOL YEAR

REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL

A. To be completed by parent or guardian.

Name	Birth Date (Y/M/D)
Parent or Guardian	Home Phone Business Phone
Physician	Phone

B. To be completed by prescribing physician LIST CONDITION(S) WHICH MAKE MEDICATION NECESSARY

_____

NAME OF MEDICATION	DOSAGE	DIRECTIONS FOR USE

Additional Comments (possible reactions, consequences of missing medication, etc.)

_____

_____

_____

_____ _____

Physician's Signature / Date

C. To be completed by parent/guardian

I request the school give medication as prescribed in the upper section of this form to my child whose name is recorded below.

_____
Name of Child

I will notify the school promptly of any changes in medications ordered.

_____
Date

_____
Signature of Parent/Guardian

Continued on reverse…

D. Each school staff member who is responsible for the administration or supervision of the medication must review the information on this card then date and sign below.

Date	Signature	Comments