# PHYSICIAN/PARENT REQUEST FOR ADMINISTRATION OF MEDICINE OR SPECIAL PROCEDURE BY SCHOOL PERSONNEL

In order for your child to receive medication or treatments in school by the Nurse, this form must be signed by both the parent and the physician and sent to school along with the medication in an original pharmacy container and/or any necessary equipment.

Name of student: ___________________________________Grade: ___________ DOB: _____/_____/_____

Address: ______________________________________________________________________

***For Physician**:*

Condition/s for which prescribed treatment is required: ____________________________________

1. **Medication or procedure**: __________________________________________________________

**Dosage/Route**: _______________/ ________________

**When this medication should be administered**: __________________

**Precautions/adverse reactions**: _________________________________________________________________

**Disposition of student following administration**, if applicable, i.e. rest, home, hospital, doctor's office, return to class: _______________________________________________________________________________

2. **Medication or procedure**: __________________________________________________________

**Dosage/Route**:_______________/ _______________

**When this medication should be administered**: __________________

**Precautions/adverse reactions:** ________________________________________________________________

**Disposition of student following administration**, if applicable, i.e. rest, home, hospital, doctor's office, return to class: _______________________________________________________________________________

3. **Medication or procedure**: ___________________________________________________________

**Dosage/Route:** _______________/ _______________

**When this medication should be administered**: __________________

**Precautions/adverse reactions:** _______________________________________________________________

**Disposition of student following administration**, if applicable, i.e. rest, home, hospital, doctor's office, return to class: _______________________________________________________________________________

Date of request______/______/______ Date of termination ______/_______/_______

____________________________________/________________________________________

Physician's Name Signature

____________________________________/________________________________________

Physician's Address Physician Telephone Number

***For Parent:***

I, the undersigned, am the parent/guardian of ____________________________________

and request that the above medication(s) and/or procedure(s) be administered to my child.

________________________________/________________ /_________________/_________________

Name/Signature Relationship Home Telephone Cell Telephone