Guardian Angels School

HEALTHCARE PROVIDER'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

One Medication per Form
(Please keep medication in its original container with an expiration date of June or later)

Student_____ Date of Birth _____Grade/Homeroom_____

Address_____Allergies _____

Name of Medication, Dosage & Route_____

Times of Day to be Administered_____

Number of Times/Intervals Medication is to be Administered_____

Date to begin Medication_____ Date to End Medication_____

Adverse/Severe Reaction that Should be Reported to Provider_____

Special Instructions for Administration of Medication_____

This student is under my care. It is not possible to arrange for this medication to be taken at home under the supervision of a parent and therefore it must be taken during school hours.

_____ _____

Date Prescriber's Signature/Printed Name Telephone

I hereby request and give my permission to the principal or his delegate (school nurse, or other responsible person) to administer the above medication to my child.

Signature of Parent or Guardian_____ Date_____

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PARENT'S REQUEST FOR THE ADMINISTRATION OF OVER-THE-COUNTER MEDICATION BY SCHOOL PERSONNEL

I hereby request and give my permission to the principal or his delegate (school nurse, or other responsible person) to administer the following over-the-counter medication to my child per instructions given. ***(Please send in the medication for your child and keep medication in its original container with an expiration date of June or later.)***

Student_____ Date of Birth_____ Grade/Homeroom_____

Name of Medication_____ Dosage_____ Route_____

Times of Day to be Administered_____

Signature of Parent or Guardian_____ Date_____