



## **Administration of Prescription Medication at School**

Since medication for the student named below cannot be scheduled for other than school hours, it is requested that school personnel administer the medication indicated below. I understand that non-medical school personnel may supervise the administration of this medication.

Name of school \_\_\_\_\_

Name of student \_\_\_\_\_

Address of student \_\_\_\_\_

Students' grade \_\_\_\_\_ Teacher \_\_\_\_\_

Name of medication \_\_\_\_\_

Dose \_\_\_\_\_ How often \_\_\_\_\_

Possible reactions that, if they occur, should be reported to the physician:

Medication should be continued, as above, until (date) \_\_\_\_\_

Date of this request \_\_\_\_\_

Physician's signature \_\_\_\_\_

Physician's address \_\_\_\_\_

Physician's phone number \_\_\_\_\_

All medication sent to school must be in the original container labeled with the student's name, medication name, and the prescribed dosage. Parent will notify the school immediately if the medication or dosage changes or if the medication is discontinued.

Parent/Guardian signature \_\_\_\_\_

Date \_\_\_\_\_

Home Phone \_\_\_\_\_ Daytime Phone Number: \_\_\_\_\_