PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

_____ of _____ is under
(Name of Pupil) (Address)
my care and should receive _____
(Name of Drug) (Dosage) (Route)
at the following time(s) _____

Date administration of drug is to begin: _____

Date administration of drug is to end: _____

Severe adverse reactions which should be reported to the doctor: _____

_____

Special instructions for administering the drug: _____

_____

Storage requirements of sterile conditions needed for the drug: _____

_____

Should a change in any of the above information occur, a revised written physician's statement must be submitted to the school.

_____ _____
Typed Physician's Name Physician's Telephone Number

_____ _____
Physician's Signature Date

* *

PARENT'S REQUEST FOR THE ADMINISTRATION OF PRESCRIBED MEDICATION BY SCHOOL PERSONNEL

I hereby request and give permission to the school nurse or the student himself/herself where the parent so permits and the school nurse is present.

Name of Pupil _____

Name of Drug _____ Dosage _____ Route _____

At the following time(s) _____

Expiration date of this request _____

Medication will be brought to the school in the original container as dispensed by the pharmacist or physician.

If any revisions in the above plan or doctor's statement occur, a written revised doctor's statement must be submitted to the school. It is understood that it is the student's responsibility to seek the medication at the proper location and time unless he/she is physically or mentally unable to do so.

Parent/Guardian Signature _____ Date _____