ADMINISTRATION OF MEDICATION TO STUDENTS
PHYSICIAN'S REQUEST FOR ADMINISTRATION OF PRESCRIPTION MEDICATIONS BY SCHOOL PERSONNEL

DATE _____

CHILD'S FULL NAME _____ is under my care and must take

medication which I have prescribed during the school day.

Name of medication (as it appears on container in which the drug is stored)

_____

Dosage and time_____

Date administration of drug is to begin _____

Possible adverse reactions to be reported to physician _____

_____

Special instructions for the administration and storage of the drug _____

_____

I or my designee(s) have trained school personnel or approved alternative training as adequate to administer the medication, have evaluated the situation, the general administration plan and if applicable, the self administration plan or emergency care plan, and deemed each to be safe and appropriate, and if applicable authorize the use of hypodermic syringes and needles or similar medical terms.

Name of Physician and Designee

_____
Print or Type

_____
Primary Phone Number

_____
Secondary Phone Number

_____
Signature of Physician