ADMINISTERING MEDICINE TO STUDENTS
Request for Administration of Medication to Students

Student's Name _____ Age _____

Parent _____ Phone _____

Doctor _____ Phone _____

Contact Names _____ Phone _____

_____ Phone _____

1. Name of medication _____
2. Purpose of medication _____

_____

3. Dosage _____
4. Time(s) to be administered _____

_____

5. Method of administration _____

_____

6. Termination date of administering medicine _____
7. Possible adverse reactions _____

_____

8. Procedures in case of adverse reactions _____

_____

_____

I request that my child, _____, receives medication at school according to the above information.

_____ _____

Parent's Signature Date

Note: Medication must be brought to school in the original, labeled container. If instructions are not specified on the container, written instructions from a doctor must accompany this application.