

**REQUEST TO ADMINISTER MEDICATION
TO A STUDENT DURING SCHOOL HOURS**

This will serve as an official request and permission for a designate of the school to dispense the below mentioned medication to my child during school hours as described below.

Parent/Guardian Signature

Date



This section to be completed by prescribing physician and/or parent:

Child's Name _____

Date of Birth _____

Address _____

Teacher _____

Medication _____

Dose _____

Time to be administered at school _____

Start date _____

Stop date _____

Special administration instructions _____

Possible reaction to be reported to physician/parent _____

Physician Signature*

Phone

Date

*Physician signature required for all prescription medications.