

REQUEST AUTHORIZATION FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

OTHER MEDICATION

Name of Student:		Gra	ade:	
Address:		Da	te:	
		DC	DB:	
Condition for which the medication is	needed to be admi	inistered during school	hours:	
Name of Medication (as appears on botto	le):			
Dosage of medication to administer:_				
Method of Administration:				
Time to be administered:				
☐ Medication will be administe	ered from	to	(end date)	
Relevant side effects to be observed (i	if any):			
If there are side effects, plan for mana	gement:			
Authorization by Parent/Legal Guard				
I request that the above medica	ation, ordered by th	ne named prescriber for	my child,	
		, be administered by	School Personnel. I	
understand that I must supply the scho	ool with the prescri	ibed medication in the	original container and	
properly labeled by a physician or pha	armacist. I understa	and that any medication	will be destroyed if it	
is not picked up within one week follo	owing termination	of the order or one wee	k beyond the close of	
the school year.				
Signature:		Date:		
Name (printed):	Relationship to student:			
Phone number(s): Home:	Cell:	Wo	ork:	
Phone number(s): Home:	Cell:	Wo	ork:	

Recv. _____ Admin + _____ 08/18