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

_____
School

_____
Grade

_____
Home Room Teacher

_____
Student's Name Street Address City Zip Code

is under may care for _____
Diagnosis

and should receive _____ at the following times
Name of Drug, Dosage, Route

_____.

Specific instructions for administration and storage of medication: _____

_____

Date to begin medication: _____Expiration date of this request: _____

Possible side effects to watch for: _____

_____ _____
Date Physician's Signature

(____)_____ (____)_____
Phone Fax

Parent's Request for a Student to Carry an Inhaler at School and During any School Activities.

I, hereby, request and give my permission to the Principal or his/her designee (school nurse or other responsible person) to administer the following medication to my child.

Name of Child: _____

Name of Drug: _____

Dosage:_____ Route:_____ at the following time(s):_____

_____ _____
Date Signature of Parent/Guardian