

REQUEST FOR ADMINISTRATION OF MEDICATION IN SCHOOL

A. TO BE COMPLETED BY THE PARENT/GUARDIAN:

I request that my child _____ grade _____ receive the medication as prescribed below by our licensed health care provider. The medication is to be furnished by me in the **properly labeled original container from the pharmacy. I understand that the school nurse or other designated person in the absence of the school nurse will assist with the administration of the medication.**

Signature (Parent/Guardian) _____

Address: _____

Telephone #: Home _____ Work _____
Cell _____

B. TO BE COMPLETED BY THE LICENSED PRESCRIBER:

I request that my patient, named below, receive the following medication:

Student: _____ Date of Birth: _____

Diagnosis/ICD-9 code: _____

Medication: _____

Dosage/Frequency/Route: _____

Time to be taken during school hours: _____

Duration of treatment: _____

Side Effects/Adverse Reactions/Recommendations: _____

Prescriber's Signature: _____ **Date:** _____

MUST BE AN ORIGINAL SIGNATURE – FAX NOT ACCEPTABLE

Health Care Provider/Title/License#/NPI#
(Please Print or STAMP):

PLEASE STAMP IN THIS BOX