REQUEST FOR ADMINISTRATION OF MEDICATION

This form is valid for no longer than twelve (12) months. One form must be used for each medication.

Box 1 – The following section must **always** be completed by the parent /guardian.

Check All That Apply:

___ Prescription Medication

___ Nonprescription Medication

Refrigeration Required: Yes:______ No:______

Complete All Of The Following Information:

Name Of Child: ____ Date Of Birth: ____/____/____ Weight: __________

Name Of Medication: ____

Parent / Guardian Signature: ____ Date: _________________

Box 2 – The following section must be completed by a licensed physician in accordance with the following conditions:

1. A physician's instruction is needed for any prescription or nonprescription medication (including specific dose, what symptom is being treated, when to administer the medication ***at school***, and the number of days the medication is to be administered.) ***"As needed" is not an acceptable duration of time for a non-prescription medication.***
2. Additional documentation is required if any non-prescription medication is to be given longer than three consecutive days in a fourteen-day period.
3. All medications must be in the original container and clearly labeled with the child's name, time(s) the medication is to be administered while at school, and the approved dosage amount.
4. No expired medications will be administered.

_______________________________ is under my care and should receive __________________________________ .
(Name Of Child) **(Name Of Medication)**

Exact Dosage: ______________________ For the Following Symptoms:____________________________________.

To Be Administered At The Following Time(s) During the School Day:____.

For The Following Period Of Time: ____.
Please note, nonprescription medications may not be given "as needed" or for longer than 3 days in a 14 day period without further documentation.

Possible side effects to watch for are: ____

Expiration date: ______________________ *(May not exceed 12 months from the date of this request for medications or food supplements)*

____ ___________________ ______________________
Signature Of Physician, Dentist Or Advance Practice Nurse ***Date Of Signature*** ***Phone Number***