PARENT/PHYSICIAN REQUEST FOR

ADMINISTRATION OF MEDICATION

Student ____

Grade/Home Room Teacher ____

Medication Prescribed ____

Amount to be Dispensed ____

Time Medication is to be Administered ___________________________________

Date to Stop Medication ____

I hereby authorize the school nurse or administrative staff member to administer the above listed medication to my child. I further authorize the school nurse to consult with the physician concerning the administration of this medication, if necessary.

________________________________	________________________________
Parent Signature	Physician Signature
________________________________	________________________________
Parent Name (Please Print)	Physician Name/Phone Number
______________	_______________
Date	Date

6.29.15