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