A picture containing text, lamp

Description automatically generated

Form 316-01

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | | | | | | |  | | | | | | | | School | | | | | | |  | | |
|  | | | | | | |  | | | | | | | | Teacher | | | | | | |  | | |
|  | | | | | | |  | | | | | | | | Grade | | | | | | |  | | |
|  | | | | | | |  | | | | | | | |  | | | | | | |  | | |
| **REQUEST FOR ADMINISTRATION OF PHYSICIAN**  **PRESCRIBED MEDICATION** | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. To be completed by PARENT or GUARDIAN | | | | | | | | | | | | | | | | | | | | | | | | |
| Student’s Name: | | | | |  | | | | | | | | | | Birth Date: | | | | | | |  | | |
| Parents/Guardian: | | | | |  | | | | | | | | | | Phone Numbers: | | | | | | | | | |
| Mother: | | |  | | | | | | | | Home: | |  | | | | | | | | Work: | |  | |
| Father: | | |  | | | | | | | | Home: | |  | | | | | | | | Work: | |  | |
| Emergency Contact: | | | | | | | | Relationship: | | |  | | Phone Numbers: | | | | | | | | | |  | |
|  | | | | | | | |  | | | Home: | |  | | | | | | | | Work: | |  | |
| Doctor: | | |  | | | | | | | | Phone Number: | | | | | | |  | | | | | | |
| Describe the medical condition which required medication to be given within school hours: | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Complete this section by attaching a copy of the pharmacy label or have your physician complete | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Medication Name | | | | | | | Dosage | | | | | | | | Directions for use and storage | | | | | | | |
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|  | |  | | | | | | |  |  | | |  | | | |  | | | | | | | |
|  | | Additional Comments: (possible reactions, consequences of missed doses) | | | | | | | | | | | | | | | | | | | | | | |
| Doctor’s Signature: | | | | | |  | | | | | | | | | | | | |  |  | | | | |
| (if required) | | | | | | (Parent/Legal Guardian Signature) | | | | | | | | | | | | |  | (Date) | | | | |
| 1. To be completed by parent or guardian: | | | | | | | | | | | | | | | | | | | | | | | | |
| I request the school to give medication as described above to my child whose name is: | | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | | | | | | | | | | | | | | | | | | | | | |  |
| I will notify the school promptly of any changes in medications described. | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | |  | |  | | | | | | | | | | |
| (Parent/Legal Guardian Signature) | | | | | | | | | | | |  | | (Date) | | | | | | | | | | |
| This card is valid for 2 years unless cancelled in writing. | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | | | | | | | | | | | |  | | | |  | | | | | | | | |
| 1. Each school staff member who is responsible for the administration or supervision of the medication must review the information on this card then date and sign below | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Date | | |  | | Signature | | | | | |  | | Comments | | | | | | | | | | |
|  |  | | |  | |  | | | | | |  | |  | | | | | | | | | | |
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|  | | | | | | | | | | | |  | |  | | | | | | | | | | |
| (Parent/Legal Guardian Signature) | | | | | | | | | | | |  | | (Date) | | | | | | | | | | |