

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 |
|  |       |  |  |  |       |
|  |       |  |  |  |       |
|  | 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. |
|  |  |  |
|  |  |  |
| 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 |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |
| (Parent/Legal Guardian Signature) |  | (Date) |