PARENTAL REQUEST AND PHYSICIAN'S ORDER FOR MEDICATION
(For students who require medication given by school personnel during school hours)

TO BE COMPLETED BY PARENT/GUARDIAN: Date of Request: _______________

Child's Name: ____________________________ Birth Date: ___________ School: _________________

I request that my child (named above) be given the medication as indicated in the physician's order below. I am aware that non-medical personnel will be administering this medication to my child. I hereby release the school administration, their agents and their employees from any and all liability that may result from my child taking the prescribed medication.

______________________________ ______________________________ ______________________________
Parent/Guardian Name (PRINT) Parent/Guardian Signature Best Contact Number(s)

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TO BE COMPLETED BY PHYSICIAN:

IT IS NECESSARY THAT THE NAMED CHILD RECEIVE THE FOLLOWING MEDICATION AT THE TIMES STATED BELOW. PLEASE ADMINISTER THE FOLLOWING AS DIRECTED BELOW:

Name and form of medication: ____

Dosage: _____________________________ Time(s) to Be Given: _________________________________

Route of Administration: ____

Other Specific Directions: ____

Purpose of Medication: ____

Side Effects to Watch for: ____

Duration of Order: ____

Is the student allowed to self-carry and self-administer? ❑ **Yes** ❑ **No**

Physician's Signature: __________________________________ Telephone Number: __________________

Physician's Name and Address: ______________________________ Fax: ____________________________
(Please print or use stamp)
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Reviewed by School Nurse _____________________________________Date_________________________