



**PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION  
BY SCHOOL PERSONNEL**

**Name of Student,** \_\_\_\_\_ is under my care and should receive  
the following **Medication & Dosage & Route,** \_\_\_\_\_  
at the following **times** \_\_\_\_\_.

Specific instructions for administration \_\_\_\_\_

Possible side effects to watch for \_\_\_\_\_

Expiration date of this request \_\_\_\_\_

Date \_\_\_\_\_ **Physician's Signature** \_\_\_\_\_

Physician's Phone Number \_\_\_\_\_

**PARENT'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL**

I hereby request and give my permission to the principal or his/her delegate (school nurse or other responsible person) to administer the following medication to my child.

**Name of Student** \_\_\_\_\_

Name of **Medication** \_\_\_\_\_ **Dosage** \_\_\_\_\_ **Route** \_\_\_\_\_

at the following **time(s)** \_\_\_\_\_

Date \_\_\_\_\_ **Parent's Signature** \_\_\_\_\_

Parent Phone Number \_\_\_\_\_