

School Fax Number _____

HEALTH SERVICE REQUEST FOR ADMINISTRATION OF MEDICATIONS
DURING THE SCHOOL DAY

Parents/guardians of students requesting medications to be administered by Health Service personnel during school hours are required to provide (1) the physician's order, (2) a parental release, and (3) the medicine supplied in the original bottle. (Ask the pharmacist to divide the medicine into two bottles with complete labels, one for school and one for home.)

Student's name _____ School _____ Date of Birth _____

Medication to be given _____

Dosage _____ Route of administration _____

Time of administration _____ Dates to be given _____

(Unless otherwise noted, this medication is to be given for the current school year.)

Reason for administration (diagnosis and ICD10) _____

Comments _____

Medical Provider signature _____ Date _____

Print name _____ Phone _____

Address _____ Fax _____

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PARENT/GUARDIAN REQUEST FOR ADMINISTRATION OF MEDICATION

I request that _____ be given _____ as
(name of student) (name of medicine)

prescribed by the physician. I also give the Licensed School Nurse and/or Registered Nurse permission to communicate with Dr. _____ regarding this medication.

Unless otherwise noted, I want the regular dose of this medicine to be administered on scheduled field trips.

Parent/Guardian _____ Date _____