

**Physician's Request for the Administration of Medication  
By School Personnel**

\_\_\_\_\_ is under my care and should receive  
Name of Student \_\_\_\_\_

\_\_\_\_\_ at the following times:  
Name of Drug, Dosage, Route \_\_\_\_\_

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

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

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

Date: \_\_\_\_\_

Physician's Signature \_\_\_\_\_

Physician's Address \_\_\_\_\_

Physician's Telephone Number \_\_\_\_\_

**Parent's Request for the Administration of Medication by School Personnel**

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

Name of Child \_\_\_\_\_

Name of Drug \_\_\_\_\_ Dosage \_\_\_\_\_ Route \_\_\_\_\_

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

Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

Principal's Signature \_\_\_\_\_

Signature of Person Administering Medication \_\_\_\_\_