

PARENT/GUARDIAN REQUEST FOR MEDICATION IN SCHOOL

Student Name	School
Grade	Room

To: Building Principal

Please comply with the attached written instructions from our physician, certified registered nurse practitioner or physician assistant regarding the administration of medication for our child.

As the parent/guardian of above named student, I relieve the school district and its employees of any responsibility for the benefits or consequences of the prescribed medication. I acknowledge that the school is not responsible for ensuring the medication is taken.

Date	Signature of Parent/Guardian
	Telephone Number

PHYSICIAN'S AUTHORIZATION FOR MEDICATION

Authorization For Medication During School Hours

_____ should receive the following prescribed
(Student's Full Name)

medication during school hours:

Name of Medication _____

Prescribed Dosage _____

Time Schedule _____

Length of Time (Days/Weeks) _____

Diagnosis/Reason for Medication (Unless Confidential) _____

Potential Reaction/Side Effects _____

Emergency Response _____

Is child qualified and able to self-administer? _____ Yes _____ No

Date	Signature of Physician Prescribing Medicine
	Physician's Telephone Number