REQUEST FOR ADMINISTRATION OF

MEDICATION AT SCHOOL

Student Name: _____School Name: _____

A. TO BE COMPLETED BY PRESCRIBING PHYSICIAN

Condition(s) which make medication necessary: _____

<table>
<tr><th>NAME OF MEDICATION</th><th>DOSAGE</th><th>DIRECTIONS FOR USE</th></tr>
<tr><td>1.</td><td></td><td></td></tr>
<tr><td>2.</td><td></td><td></td></tr>
<tr><td>3.</td><td></td><td></td></tr>
<tr><td>4.</td><td></td><td></td></tr>
<tr><td colspan="2" rowspan="3">Additional comments: (possible reactions, consequences of missing medication, storage duration)</td><td>Physicians Name: (please print)</td></tr>
<tr><td>Physicians Signature:</td></tr>
<tr><td>Date:</td></tr>
</table>

B. TO BE COMPLETED BY PARENT OR GUARDIAN – INFORMED AUTHORIZATION AND RELEASE

I request the school to give medication (must be in the original container) as prescribed on this form to my child, whose name is: _____.
I will notify the school, in writing, promptly of any changes in medication or dosages ordered. I will provide the medications listed above.

- ☐ EPIPEN – I request that the administration of the EpiPen be provided. I understand that the service will be provided by a person without medical or nursing training. It is my responsibility as parent / guardian to provide the school with current EpiPens for my child's use and care.

_____
Date

_____ _____
Name – Parent/Guardian Signature – Parent/Guardian