PRESCRIBED MEDICATION FORM

ADMINISTRATION OF PRESCRIBED MEDICATION FORM

Student _____ Grade _____

Birthdate _____ School _____

Name of Family/Agency _____ Home Phone _____

Home address _____ Work Phone _____

REQUEST AND AUTHORIZATION

I, hereby, request and authorize the administration of the following prescribed medication for my child _____

by non-medically trained staff at _____ school.

Date _____ Signature _____

Name of student's pharmacist _____ Phone _____

Medication Prescribed *Dosage* *Side effects*

1.

2.

3.

Please state duration of time to be covered by this parental and doctor's authorization (not to extend beyond the current school year) _____

Name of student's doctor _____ Phone _____

Doctor's signature _____

Other pertinent information _____

Note:

1. Families/Agencies are required to contact the Principal of the school if there is a change in medication and/or dosage.
2. A unit dosage system must be utilized.
3. This form is to be completed in quadruplicate (4 copies).
    a) School c) Doctor
    b) Family/Agency d) Pharmacist
4. It is expected that only the daily requirement will be sent to school unless other arrangements are made with the Principal.