

PHYSICIAN REQUEST FORM

For Administration of Drugs other than Epi-Pens and Inhalers

Since any drug prescribed by a physician for the student listed below cannot be scheduled for other than school hours and the administration of such drug may be supervised, it is requested that the drug be given as indicated below be and will be supervised by trained school personnel.

	/	
Name of Student	School	Class
Address of Student:		
Drug to be administered:		
Dosage:	Time/Interval:	
Possible reactions that, if they occur, sh	nould be reported to the physician: _	
Administration of drug listed above to l	be initiated on (date):	
Administration of drug listed above to l	be continued until (date):	
Parent/guardian may change dosage of parent/guardian has requested authority	prescribed drug within the following to change prescription):	ng parameters (only complete if
Special instruction for administration of	f drug, including sterile conditions	and storage:
Physician's Name and Address:		
Physician's Phone Number and Emerge	ency Phone Number (if different): _	
Physician acknowledges that the drug to might occur are consistent with supervi	o be administered, the student's consision of administration of drug by so	ndition and the possible side reactions that chool nurses or trained school personnel.
*Signature of Physician	Date of R	Request
To be completed by school personnel: Person(s) authorized to supervise admin in board policy, designate a trained staff		(The building administrator may, as set forth and dispensation of drugs.)
Authorized School Personnel (Print Na	Signature of Prince	cipal Date

*This form MUST be signed by the physician



PARENTAL PERMISSION FOR ADMINISTRATION OF MEDICATION

Principal		School
FOR: Student	G	rade
We (I), the undersigned, who are the paradministration of a drug be supervised in the control of a member of the trained school staff,	in accordance with the instructio understand that said drug is to be	n of our Physician, e administered under the supervision
Further, we (I) the undersigned, agree to pharmacist properly labeled by same, the name, date, pharmacy name and telephorand storage directions. A label is not rewhich are drugs prescribed by a physician	nis label to include name of the done number, prescribed dosage a equired for over the counter drug	lrug, student's name, physician's and frequency and special handling s not dispensed by a pharmacist
Administration of the prescribed drug verwised physician request form, or until administer the drug.		
The parents shall have sole responsibilichild has the responsibility for both pre		
The parent/guardian, or other person has tatement to the building principal signer the drug treatment plan.		
**Signature of Parent/Guardian:Address of Parent/Guardian:		Date:
Address of Parent/Guardian: Telephone Numbers: Home:	Business:	Cell:
**If children are in a foster home and p	lacement is by an agency that he	olds custody, agency personnel must

sign. If the child is a ward, a court-appointed guardian must sign.