

PARENT'S REQUEST FOR ADMINISTRATION OF MEDICATION

Since it is necessary for my child to receive medication during school hours, I request that the medication be administered to my child in accordance with school policy and our physician's instructions below.

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date

PHYSICIAN'S REQUEST FOR ADMINISTRATION OF MEDICATION

STUDENT: \_\_\_\_\_ GRADE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ D.O.B. \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_

PRESCRIBED MEDICATION: \_\_\_\_\_

DOSAGE OF MEDICATION: \_\_\_\_\_

TIME & METHOD OF ADMINISTRATION: \_\_\_\_\_

POSSIBLE REACTIONS TO MEDICATION: \_\_\_\_\_

CONTINUE MEDICATION FROM: \_\_\_\_\_ TO: \_\_\_\_\_

COMMENTS:

\_\_\_\_\_  
PHYSICIAN'S SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PHYSICIAN'S ADDRESS

\_\_\_\_\_  
TELEPHONE

EAST IRONDEQUOIT CENTRAL SCHOOL DISTRICT