Request for Administration of Medication at School **Check if not applicable ☐**

Student's Full Name: _____ School Name: _____

Section A – To be completed by prescribing physician / licensed medical professional.

Condition(s) which make medication necessary: _____

Name of Medication	Dosage	Direction for Use
1.		
2.		
3.		
4.		

Additional Comments (possible reactions, consequences of missing medication, storage duration):	Physician's Name:
	Physician's Signature:
	Date:
	Office Stamp:

Section B – To be completed by parent/guardian – Informed Authorization and Release
I request that staff give medication, as prescribed on this consent form to my child. I understand that:

- ✓ I agree to supply the medication to the school, in the original container with the child's name, prescribing physician and pharmacist's direction for use including dosage.
- ✓ If changes occur, I will contact the school and provide revised instructions. I am aware I am required to update this information each September.
- ✓ I am aware that the Nursing Support Services for the school will be informed of my child's condition and medication and the nurse may contact me directly as necessary.
- ✓ I am aware that staff and other personnel working with my child will need to know of my child's condition and the medication required.
- ✓ If non prescription medication is given, a note from the parent must be provided.

	Print Name	Signature	Date
Parent/Guardian Name:			
Principal/Designate:			