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