

Date _____

Pupil _____ B.D. _____ Grade _____ School _____
Last First M.I.

Attending Physician(s) _____

Physician's address _____

Physician's Telephone _____ Fax _____

MEDICATION(S):

(1) Name of medication _____ Dosage _____

Time of administration _____ **Reason** for medication _____

Date to start administration _____ Date to end administration _____

Comments/Possible side effects

(2) Name of medication _____ Dosage _____

Time of administration _____ **Reason** for medication _____

Date to start administration _____ Date to end administration _____

Comments/Possible side effects

Physician: (Physician's signature **required** for **prescription** medications to be administered)

If student requires an Epi-pen, TwinJet or inhaler, plus an additional Epi-pen, TwinJet or inhaler required for bus transportation, please provide an **extra** prescription to parent so they can provide the additional pen.

Physician's signature for medication administration by staff _____ Date _____

Physician's signature for self carry/self administration of EpiPen/Inhaler _____ Date _____

(circle)

Parent/Legal Guardian:

I hereby request that my child be administered prescribed medication at school by school personnel. I understand that the medication will be administered exactly as per directions of my above-named physician. I will notify the school of changes or discontinuance of this medication(s) by completing a new form.

Parent/Legal Guardian's signature: _____ Date _____

Address _____

E-Mail _____ Cell Phone _____