MEDICATION ADMINISTRATION REQUEST

Student: _____ Date of Birth: _____

Teacher: _____ Grade: _____

Medication: _____ Rx #: _____

Prescribing Physician: _____ Dosage: _____

Times to be Given: _____

Dates to be Given: _____

Special Instructions: _____

Reason/Health Problem: _____

Date/Time of First Dose: _____

Parent/Guardian Signature: _____ Date: _____

Daytime Phone: _____

*Only those medications necessary for student's medical care will be administered at school.

*Most medications, even those ordered three times a day, can be given at home and will not be given at school.

*All medications must be in the original container.

*All containers must be labeled with name, medication, instructions, and date.

*No medication will be given without a parent's written consent.

*First time doses of medication will not be given at school.

*Over the counter medications will not be given for more than 3 consecutive days without physician orders.