

**PARENT'S REQUEST FOR ADMINISTRATION OF MEDICATION**  
**BY SCHOOL PERSONNEL**

**PLEASE PRINT:**

Name of Pupil \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian's Name \_\_\_\_\_

Teacher \_\_\_\_\_ Grade \_\_\_\_\_

Physician's Name \_\_\_\_\_ Telephone \_\_\_\_\_

Condition for which medication is to be given: \_\_\_\_\_

Name of Medication \_\_\_\_\_ Prescription # \_\_\_\_\_

Dosage: \_\_\_\_\_ Time to be given at school: \_\_\_\_\_

Name of Medication \_\_\_\_\_ Prescription # \_\_\_\_\_

Dosage: \_\_\_\_\_ Time to be given at school: \_\_\_\_\_

How long will medication be given? days \_\_\_\_\_ weeks \_\_\_\_\_ months \_\_\_\_\_

Special instructions if any:

I CERTIFY THAT IT IS NECESSARY TO GIVE THE ABOVE  
MEDICATION DURING SCHOOL HOURS AND THAT IT IS  
PROVIDED IN THE ORIGINAL CONTAINER. IT MAY BE  
ADMINISTERED BY A MEDICALLY UNTRAINED DESIGNATE OF  
THE SCHOOL OR THE SCHOOL NURSE OR PRINCIPAL.

Parent Signature