



Parent/Guardian Request for Administration of Medication

I request and give my consent for the school nurse or designated school employee see that my child, _____ receives medication as directed below. My child must have this medication during school hours. The medication is to be furnished by me *in the original container and is to be labeled (current pharmacy label if prescription*) and given as follows:*

Name of medication	Number	Additional Info
Prescription number		or over the counter
Dosage to be given		
Time of day to be taken		or as needed
Reason for medication		
Expected duration of treatment		
Physician's name & phone		

I understand that all medications must be brought to the Health Center where they will be secured and that school personnel will not be responsible for any reaction to medications given according to the above direction. I agree to notify the school immediately of any change in medication.

I understand that I am responsible for retrieving any unused medication at the end of the school year and understand that any *medication not picked up will be discarded.*

Parent/Guardian signature _____

Date _____

Daytime phone number(s) _____

Cell phone number(s) _____

*School personnel must follow the dosage and *time(s)* on the prescription label. Any dose changes must have a **written** physician's order. Prescription must be for the current year.