PHYSICIAN AND PARENT REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

Student	
Address	
City/State/Zip	
Name of Medication and Dosage	
Times of Day to be Administered	
Number of Times/Intervals Medication is to be Administered	
Date to Begin Medication Date to End Medication	n
Adverse/Severe Reaction that Should be Reported to Physician	
Special Instructions for Administration of Medication	
This medication can be safely administered by non-medical personnel	es 🗆 No
It is impossible to arrange for this medication to be taken at home and, therefor during school hours \Box Y	e, it must be administered es
This student is under my care. It is not possible to arrange for this medication supervision of a parent and therefore it must be taken during school hours.	to be taken at home under the
Physician's Printed Name	Tel
Physician's Signature	Date
Please regard my signature below as my assurance that I release School, PSI, and any or a	
officers or employees from any liability or damages resulting from the conseque child's taking or failing to take this medication at the times prescribed. I also a in writing of any revision in the physician's prescription. I have had the opport have been fully answered to my satisfaction.	gree to keep the school informed
Parent's Printed Name	Tel
Parent Signature	Date