

REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL

A. TO BE COMPLETED BY PARENT OR GUARDIAN

_____	_____	_____
STUDENT NAME	BIRTH DATE (year/month/day)	CARE CARD # (PHN)
_____	_____	_____
PARENT OR GUARDIAN NAME	HOME PHONE	BUSINESS PHONE
Please print		

NOTE TO PHARMACISTS: Please apply Pharmacy label for prescriptions from doctors only. No non-prescription medications are accepted.



B. TO BE COMPLETED BY PARENT OR GUARDIAN

I request the school to give medications as prescribed on this form to my child whose name is: _____

I will notify the school promptly of any changes in medications ordered: _____

Signature of Parent or Guardian

Short Term Medication: This medication should be given at _____ (time).

C. TO BE COMPLETED BY SCHOOL PRINCIPAL

The information on this form has been reviewed with appropriate staff.

PRINCIPAL'S SIGNATURE: _____ **Date:** _____

