JEFFERSON LOCAL SCHOOL DISTRICT

PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

STUDENT NAME: ____

NAME OF MEDICATION: __________________________________**DOSE:** ________________________

ROUTE OF ADMINISTRATION: ______________________________**TIME:** ________________________

ADDITIONAL INSTRUCTIONS: ____

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SIDE EFFECTS TO MONITOR: ____

THIS REQUEST EXPIRES:____________________________

PHYSICIAN SIGNATURE:____**DATE:**___________________

PHONE NUMBER:_________________________________

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

I hereby request and give my permission to the principal or his designee to administer the following medication to my child and agree:

1. To deliver the medication to the school and NOT send it with my child
2. To notify the school if there are any changes related to the medication or if it is discontinued.

CHILD'S NAME: ____**DATE:** _____________________

NAME OF MEDICATION: ___________________________________**DOSE:** ____________________

ROUTE OF ADMINISTRATION: _______________________________**TIME:** ____________________

PARENT SIGNATURE: ____