REQUEST FOR ADMINISTRATION OF MEDICATION/PROCEDURE

PARENT/GUARDIAN CONSENT FORM

(Top Portion to be filled out by Parent/Guardian)

NAME OF CHILD: _____DOB _____SCHOOL _____Grade_____

Medication Name	Dosage	Time	Physician	Diagnosis

BEGINNING DATE: _____ SCHOOL YEAR _____

IS CHILD TAKING ANY OTHER MEDICATION AT HOME? : _____ YES _____ NO

NAME OF OTHER MEDICATION: _____

I request that the school nurse administer the medication listed above. I understand that I need to have a Physician's Order (below) signed by the Doctor BEFORE the medication or procedure can be done in the school.

I understand that the first dose of any new medication needs to be given at home. I will send the medication in the ORIGINAL CONTAINER or PRESCRIPTION BOTTLE with the correct instructions labeled on it.

_____

Signature of Parent/Guardian Date Phone

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Please Initial the following options :

MEDICATION/PROCEDURE TO BE GIVEN/PERFORMED ON EARLY OUT DAYS:____ YES_____NO

MEDICATION ON AN OUT-OF-TOWN FIELD TRIP WILL BE

(Parent and MD Please initial one of the following)

1) Omitted that day: Parent _____ Physician_____

2) Given before field trip or on return: Parent_____ Physician_____

3) Must be given as ordered, cannot be altered: Parent_____ Physician_____

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(Lower portion TO BE COMPLETED BY PHYSICIAN)

PHYSICIAN'S ORDERS FOR MEDICATION/PROCEDURE

(To Be Filled Out By Doctor's Office)

The following medication/procedure has been prescribed by me and is necessary for _____to take during school hours.

(Child's Name)

Med Name or Procedure	Dosage	Time	Physician	Diagnosis

_____ _____

(**Physician's Signature**) (Date)