Parent Request for Administering Medication

Date _____

Name of Student. _____

Name of Medication. _____

Dosage of medication. _____

Time of day medication is to be dispensed. _____

Name of person prescribing medication. _____

Telephone of person prescribing medication. _____

Possible side effects of medication _____

Special instructions _____

_____

I authorize my above named child to be permitted to receive the above listed medications: with _____ or without _____ calling me each time.

It is understood by the undersigned that school personnel will not be responsible for possible side effects from the administration of the above medication.

_____ _____

Parent or Guardian signature date

FOR OFFICE USE ONLY

Date	time	dosage	initials	comments