

**PHYSICIAN/PARENT MEDICATION REQUEST FORM**

School \_\_\_\_\_ Grade \_\_\_\_\_ Homeroom \_\_\_\_\_

**PHYSICIAN’S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL** (To be filled in and signed by physician)

\_\_\_\_\_  
(Student’s Name) (Student’s Date of Birth)

\_\_\_\_\_  
(Student’s Address)

is under my care and should receive \_\_\_\_\_  
(Name of medication and Route)

\_\_\_\_\_ at the following times \_\_\_\_\_  
(Dosage) (Time of administration)

Administration of this medication should begin \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Administration of this medication should end \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Reason for medication: \_\_\_\_\_

Specific instructions of administration \_\_\_\_\_

Possible side effects of medication \_\_\_\_\_

I, as this child’s attending physician, feel that it is essential this medication be given during school hours in order for my patient to function adequately in school.

\_\_\_\_\_  
(Print or Type Physician’s Name) (Phone)

\_\_\_\_\_  
(Physician’s Signature) (Date)

\*\*\*\*\*

**PARENT’S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL.** (To be filled in and signed by parent)

I hereby request and give my permission to the school nurse, principal, or his designee to administer medication to my child.

I release the Board of Education of the Three Rivers Local School District and their designated representative from any liability concerning the giving or non-giving of this medication to my child. I also agree to notify my child’s principal should any of this information change.

Parent/ Guardian’s Name: \_\_\_\_\_  
(Please Print or Type)

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_