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)

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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: _____