REQUEST FOR ADMINISTRATION OF MEDICATION

Use a separate authorization form for each medication

Student Name _____ Date of Birth_____ School Year _____

TO BE COMPLETED AND SIGNED BY PARENT OR GUARDIAN:

If medication needs to be administered during the school day, please submit this completed form before medication is sent to school. ***ALL*** medications will be kept in a locked cabinet in the nurse's office. Medication ***MUST*** be brought to the school office by a parent or guardian.

NO MEDICATION WILL BE ADMINISTERED WITHOUT DIRECTIONS FROM THE CHILD'S PHYSICAN AND PARENT/GUARDIAN. A NEW FORM MUST BE FILLED OUT FOR ANY CHANGE IN DOSAGE.

I am the parent/guardian of the above-named student. I request that the Town and Country School nurse, administrative staff, or classroom teacher/assistant give my child the following prescribed medication. I hereby acknowledge that I have read and understand the School Board Regulations relating to the taking of medication during school time. I authorize a representative of the school to share information regarding this medication with the licensed prescriber listed below.

Parent/Guardian Signature_____Date_____

Medication Authorization

(For Use by Licensed Prescriber ONLY)

Name of Medication_____

Dosage to be Given_____

Time(s) to be given_____

Side effects to report_____

Serious reaction/adverse side effects from this medication may occur ____Yes _____No

If yes, describe: _____

Physician's Signature_____ Date_____

Physician's Name (printed)_____

Physician's Phone Number_____FAX #_____