PARENT REQUEST FOR MEDICATION ADMINISTRATION

Date: _____

I give my permission for the school nurse to administer the following medication to my

Son/daughter _____ for the time period listed below.

Name of Medication: _____

Dosage of Medication: _____

Time to be given: _____

Physicians Name: _____

Dates of Administration: _____

Signature of Parent/Guardian: _____

Nurse will fill out the bottom portion of this page:

_____

_____ Physician note obtained (Food Allergy Care Plan, Asthma Action Plan, Seizure Action Plan etc.)

_____Medication in original bottle/box and labeled properly