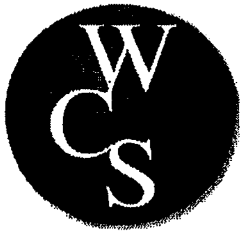

WARREN CONSOLIDATED SCHOOLS

Student: ____________________

Grade: ________ Teacher: ____________

School: ____________________

School Phone: ________________

School Fax: ________________

REQUEST FOR ADMINISTRATION OF MEDICATION TO STUDENT

Dear Parent/Guardian,

Under certain conditions, as a service to you and for the welfare of your child, parental requests for the in-school administration of necessary prescribed and/or over-the-counter medication/health procedures will be honored.

Prescription Medication: ● Must be in Original Pharmacy Container ● Provide Student's Name ● Name of Drug ● Dosage ● Frequency ● Doctor's Name ● Pharmacy Name ● Date Issued ● Prescription Number ● Expiration Date

The written statement below, signed and dated by the attending physician, supporting this signed parental request is required. The physician's statement must also provide clear directions for administering the medication or health procedure in school.

PARENT

As indicated by the prescribing physician below, I do hereby request and authorize that the prescribed and/or over-the-counter medication/health procedure be administered to:

Student Name: ____________________ Date of Birth: ____________

Address: ________________ City: ____________ State: ________ Zip: ________

Home Phone: ____________ Cell Phone: ____________ Work Phone: ____________

Parent/Guardian Name (printed): ____________________

Parent/Guardian Signature: ____________________ Date: ____________

PHYSICIAN

I recommend that prescribed and/or over-the-counter medication/health procedure listed below be administered to:

Student's Name: ________________ Diagnosis: ________________

Name of Medication/Health Procedure: ____________________

Dosage: ________________ Times/Frequency: ________________

Give Medication **BEFORE LUNCH**: yes / no **AFTER LUNCH**: yes / no

Route of Administration: ____________________

First Date of Administration: ____________ Last Date of Administration: ____________

Additional Directions/Precautions: ____________________

____

Physician Address: ____________________

Physician Phone Number: ____________________

Physician Name (printed): ____________________

Physician Signature: ________________ Date: ________

Imprint Physician Office Stamp Below:

Updated: 8/12/20