Request for Administration of Medication
Or use of Medical Equipment in School

Name of Student________________________________ Date of Birth______________

Address____

Diagnosis____

Reason Medication/ Treatment must be given at school______________________________

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Name of Medication/ Treatment/ Equipment______________________________________

Dose:____________ Time(s) to be given in school____________________________

Date Begin:________________ Date End: ___________________________________

Instructions:____

Contraindications: ____

Side Effects: ____

Actions to be taken/Treatment of side effects _____________________________________

Is any restriction of activity necessary? Yes_____ no _____

If yes, describe: ____

Is student taking any other medication? Yes _____ no _____

If yes, name of medication ____

Print Doctor's Name____

Doctor's Signature____________________________________ Date_______________

Address _____________________________________ Phone______________

I authorize select school personnel to administer the above medication, or to use the equipment as prescribed by my child's health care provider, whose **signature appears on this form.**
My child may self-administer medication/ equipment as determined appropriate by the school nurse. I authorize the school nurse to contact my child's health care provider as needed regarding this medication/ equipment and/ or my child's response.

Parent Signature______________________________________ Date_________________

Telephone Number ______________________ Emergency Number ___________________