PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

This form is to be used for students attending the Shelby County and Sidney City Schools including the Parochial Schools.

To be completed by your family physician:

Student's Name _____ Date of Birth _____

Address _____ School District _____

City _____ State _____ Zip _____

The above named student is under my care and should receive:

Name of Drug _____ Dosage _____

To be given as follows _____

Side effects to watch for _____

Physician Name (please print) _____ Date _____

Physician signature _____ Stamp with name and address:

PARENT'S PERMISSION FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

I hereby request and give my permission to the principal or a designee (secretary, teacher, school nurse (public health nurse) or other responsible person to administer the following medication to my child:

Name of Student _____ School _____ Grade _____

Name of Drug/medication _____ Dosage _____

Administer at the following time (s) _____

Beginning (date) _____and until (expiration date) _____

_____ _____ _____

Parent's phone number signature of parent or guardian date

NOTE: THE PARENTS OF THE STUDENT MUST ASSUME RESPONSIBILITY FOR INFORMING THE PRINCIPAL OF ANY CHANGE IN THE STUDENT'S HEALTH OR ANY CHANGE IN THE PRESCRIBED MEDICATION. ANY CHANGES TO THE ABOVE PRESCRIPTIOIN (DOSAGE OR ADMINISTRATION) WILL REQUIRE THE COMPLETION OF A NEW FORM. PARENTS MUST SEND MEDICATION TO SCHOOL IN IT'S **ORGINAL** CONTAINER.

_____ _____

School Official's Signature (Acknowledging Receipt) Date

Revised 7/19/07