

**REQUEST FOR ADMINISTRATION OF MEDICATION TO STUDENTS**

Student Name:		D.O.B. MM/DD/YYYY
Parent Name:	Phone Number:	
	Business Number:	
Parent Name:	Phone Number:	
	Business Number:	
Emergency Contact:	Phone Number:	
Emergency Contact:	Phone Number:	
Doctor/Clinic:	Phone Number:	

<b>Medications</b>
Name: Purpose:  Dosage: Administration time(s): Administration Termination Date:
<b>Allergies</b>
Known Allergies: Possible Adverse Reaction(s):  Procedure in case of Adverse Reaction(s):

I request that my child, \_\_\_\_\_, receives medication at school according to the above information.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**Note: Medication must be brought to school in the original, labelled container. If instructions are not specified on the container, written instructions from a doctor must accompany this application.**

**Where procedures beyond a written prescription are required, written instructions from the doctor shall be attached.**