



REQUEST TO ADMINISTER MEDICATION

Name / Nombre: _____ DOB: _____

School / Escuela: _____ Grade / Grado: _____ Date / Fecha: _____

TO BE COMPLETED BY PHYSICIAN / HEALTH CARE PROVIDER

_____ is under my care for _____
Child's Name Condition / Diagnosis
and is being prescribed the following medication to be given at school.

SCHEDULED MEDICATION

1.) MEDICATION: _____ DOSAGE: _____ TIME: _____

SIDE EFFECTS / CONTRAINDICATIONS: _____

Is child to receive this medication at home? Yes ___ No ___ If parent informs the school that the child did not receive an ordered AM dose of this medication; may it be administered at school? Yes ___ No ___ May administer no later than AM / Dosage _____

2.) MEDICATION: _____ DOSAGE: _____ TIME: _____

SIDE EFFECTS / CONTRAINDICATIONS: _____

Is child to receive this medication at home? Yes ___ No ___ If parent informs the school that the child did not receive an ordered AM dose of this medication; may it be administered at school? Yes ___ No ___ May administer no later than AM / Dosage _____

Inhaler may be carried by the student at school: Yes ___ No ___	Epipen may be carried by the student at school: Yes ___ No ___
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OVER THE COUNTER MEDICATIONS (AS NEEDED)

Specify medication(s) to be administered below. Tablets, capsules, or liquid will be administered according to age/weight appropriate dosage as indicated on package instructions unless otherwise indicated.

<input type="checkbox"/> PAIN RELIEVER/FEVER REDUCER	1. _____	2. _____
<input type="checkbox"/> UPSET STOMACH/ACID INDIGESTION	1. _____	2. _____
<input type="checkbox"/> ALLERGY/ANTIHISTAMINE	1. _____	2. _____
<input type="checkbox"/> COLD/FLU SYMPTOMS	1. _____	2. _____
<input type="checkbox"/> OTHER	1. _____	2. _____

Physician/ Health Care Provider
Signature

Phone#

Date

TO BE COMPLETED BY PARENT / GUARDIAN

I hereby authorize the above medication be given to my child as stated by my child's Physician / Health Care Provider. It is also understood to be the parents responsibility to instruct the child to go to the nurse's office to receive medication. I further release the aforesaid health care provider from all legal responsibility or liability which may arise from the act which I authorized above. This release shall be valid for a period of one year from the date doctor's signature.

Autorizo la administración de el/los medicamentos recetado/s por el médico proveedor de salud para mi niño/a. Es la responsabilidad de el padre / guardián que el niño/a vaya a la oficina de le enfermera por el medicamento. Yo retiro la responsabilidad del distrito escolar y departamento de enfermería de todo problema legal que se pueda presentar con esta autorización. Esta autorización será valida por el periodo de un ano a partir de la fecha de firma de el doctor.

Parent / Guardian signature – Firma de Padre / Guardian
HA/MED/01

Date / Fecha
REV-24