2009-2010

WAYNE LOCAL SCHOOLS

Denise Richmond, R.N., School Nurse

MEDICATION ADMINISTRATION REQUEST FORM

Both sections of this form must be completed in order to administer non-prescription or prescription medication at school. This Medication Administration Request Form will only be in effect for the 2008-09 school year.

PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL
(This section must be completed by the physician only)

______________________________ is under my care and should received
Student's Name

____
Name of Drug, Dosage, Route

at the following times ______________________________.

Specific instructions for administration ______________________________

Possible side effects to watch for ______________________________

Expiration date of this request ______________________________

______________________________ ______________________________
Physician's Signature Date

____
Physician's Phone Number

PARENT'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL
(This section must be completed by the parent/guardian)

I hereby request and give my permission to the School Nurse or her delegate (principal or other responsible person) to administer the following medication to my child.

Name of Child ______________________________

Name of Drug ____________ Dosage ____________ Route ____________

at the following time(s) ______________________________

______________________________ ______________________________
Signature of Parent or Guardian Date