



Request from Parents & Physicians for Medication Administration in School

Name: _____ **Grade** _____

Teacher: _____ **Date** _____

Diagnosis: _____

Name of Medication: _____

Date Prescribed: _____

Dosage: _____ **Time Administered:** _____

Directions for administering: _____

Comments: _____

Please return this form to school, as soon as possible, along with the medication prescribed to be administered during school hours. The label of the medication container must identify the name of the medication and the name of the child for whom the medication is intended. *(EpiPens must be sent in along with the box that it came in and/or have the pharmacy put the label directly on the pen case.)*

Signature of Physician: _____

Address: _____

Phone: _____

Signature of Parent: _____

Phone: _____