

Our Lady of Peace School
Physician's request for the Administration of Medication by School Personnel

Student Name _____ Date of Birth _____

School _____ Grade _____

Parent Section

Please review the following steps required for permission of school personnel to administer any medication to your child and sign this section:

1. This form must be completed by both the parent (top section) and physician (bottom section).
2. Medication must be kept in the student's prescription labeled bottle. (Pharmacy may provide an extra bottle for long-term medication.) Prescription label must match instruction from doctor. If it is a non-prescription drug, it must be in the original container.
3. A revised statement signed by the physician must be provided when there is a change in the dosage to be given and a new form provided each school year.

When possible, give medication outside of school hours. For example, to be able to administer four (4) doses to the child, it might be given before school, immediately after school, before child's bedtime and before parents' bedtime. Please contact the school nurse if you have questions.

Signature of Parent _____ Date _____

Physician Section

I, the undersigned physician am certifying that medication for the student listed below cannot be scheduled for other than school hours. Further, I realize that medically untrained personnel may supervise the administration of such medication.

I verify that this medication must be taken by _____
Name of Student

Name of Medication _____ Dosage to be # of pills
Administered _____ supplied _____

Any severe adverse reactions, which should be reported to the doctor _____

Special instructions for administering the medication, including storage requirements or sterile Conditions _____

Time medication Prescription Expiration
Is to be taken _____ start date _____ Date _____

Physician's Signature _____ Date _____

Physician's printed name _____ Phone _____