St. Francis de Sales School

PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL –
<u>PRESCRIPTION AND NON PRESCRIPTION</u>

Name of child ____ is under my care and should receive

(name of drug) ____Dosage _________________________________

at the following time(s) ____

Any specific instructions: ____

Possible side effects to watch for ____

Expiration date of this request ____

Date _________________________ ____

Physician's Signature and Phone Number

--AND ---

PARENT'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL –
OVER THE COUNTER MEDICATION

I hereby request and give my permission to the principal or other responsible person to administer the following medication to my child.

Name of Child ____

Name of Drug ____

Dosage ____

At the following time(s) ____

Date _________________________________ ____

Signature of Parent/Guardian