REQUEST FOR ADMINISTRATION OF MEDICATION/PROCEDURE

PARENT/GUARDIAN CONSENT FORM

(Top Portion to be filled out by Parent/Guardian)

NAME OF CHILD: ____DOB ____SCHOOL _____ Grade______

Med Name	Dosage	Time	Physician	Diagnosis

BEGINNING DATE: _______________ SCHOOL YEAR: _________________
IS CHILD TAKING ANY OTHER MEDICATION AT HOME? : ______ YES ______ NO
NAME OF OTHER MEDICATION: ____

I request that the school nurse administer the medication listed above. I understand that I need to have a Physician's Order (below) signed by the Doctor BEFORE the medication or procedure can be done in the school. I understand that the first dose of any new medication needs to be given at home. I will send the medication in the ORIGINAL CONTAINER or PRESCRIPTION BOTTLE with the correct instructions labeled on it.

____

Signature of Parent/Guardian **Date** **Phone**

.Please Initial the following options :
MEDICATION/PROCEDURE TO BE GIVEN/PERFORMED ON EARLY OUTDAYS:_____YES_____NO
MEDICATION ON AN OUT-OF-TOWN FIELD TRIP WILL BE (Parent and MD Please initial one of the following)

1) **Omitted that day:** **Parent _____ Physician________**
2) **Given before field trip or on return:** **Parent______ Physician________**
3) **Must be given as ordered, cannot be altered:** **Parent______ Physician________**

(Lower portion TO BE COMPLETED BY PHYSICIAN)

PHYSICIAN'S ORDERS FOR MEDICATION/PROCEDURE

(To Be Filled Out By Doctor's Office)

The following medication/procedure has been prescribed by me and is necessary for ____to take during school hours.
(Child's Name)

Med Name or Procedure	Dosage	Time	Physician	Diagnosis

____

(Physician's Signature) (Date)

jgRN 8/2017