

**McLouth Schools
Medication Administration Request**

Student Name _____ Date of Birth _____

Allergies _____ Grade _____

Physician _____

Prescription Information (Homeopathic, herbal, natural remedies cannot be delegated without physician's order.)	
Medication _____	Dosage _____
Time of day to be given _____	Start Date _____
Expected Days of Use _____	
Reason for Medication _____	
Possible Side Effects _____	
Physician Signature _____	Date _____
(or must have current prescription label on original container)	
Phone _____	

The following to be completed by parents/guardian:

I hereby certify that my son or daughter, named above, has previously had at least one dose of the above medication and had no adverse reactions. I request that this medication be administered at school as directed above. I understand that it is my responsibility to furnish this medication. Further, I understand school policies regarding medication administration.

I hereby authorize my child's school's nursing personnel to exchange information regarding this request/medication or this prescription, with the physician or with the pharmacy as identified on the affixed label for purposes of clarification or risk assessment.

Date _____ Signature of Parent/Guardian _____

Note: The medication must be brought to school in the original container appropriately labeled with student name. Prescription medications must be labeled by the pharmacy or physician, stating the name of the student, the date, the medication, the dosage, and the number of days to be administered.

This request is valid for the current school year only.

School use: Prescript no.: _____
Pharmacy: _____
Prescript date: _____
Staff Initial: _____