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: _____