AP 328-1 Request for Administration of Medication at School

A. (STUDENT NAME) _____

Surname **Given Name**

photo

B. TO BE COMPLETED BY PRESCRIBING PHYSICIAN (Condition(s), which make medication necessary)

Name of Medication	Dosage	Directions for Use
1.		
2.		
3.		
4.		

(Additional comments – possible reactions, consequences of missing medication, etc.)

_____
Physician's Signature

_____
Date

C. TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN

I request the school to give medications as prescribed on this form to my child whose name is recorded below

I will notify the school promptly of any changes in medications ordered

_____
Name of Child

_____
Signature of Parent/Legal Guardian

_____
Date

D. **Each School Staff Member who is responsible for the administration or supervising of the medication must review the information on this form, then date and sign below.**

Date	Signature	Comments