REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL

PARENT

I here by give permission for the nurse or authorized school personnel to administer the following medication to my child for the current _____ school year. This permission shall be effective during the school day, on school property, and at all school activities.

Name of child: _____

Name of medication: _____

Dose to be administered: _____

Diagnosis: _____

Time and circumstances of administration: _____

_____

Start date: _____ End date: _____

Name of prescribing Physician:

_____

(first) (last) (MD, DO, DDS, DMD)

_____ _____

(Parent/Guardian Signature) (Date)

Parkway School District Form #233B (05/1/16)