

## Request for Medication Administration

(to be completed by parent or guardian)

Student's name \_\_\_\_\_ Birth date \_\_\_\_\_ Grade \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Parent's name \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Emergency contact \_\_\_\_\_

Medication to be administered \_\_\_\_\_

Dosage to be administered \_\_\_\_\_

Time or interval at which each dosage is to be administered \_\_\_\_\_

Name of Physician authorizing administration \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Date to begin administration \_\_\_\_\_

Date to cease administration \_\_\_\_\_

I request that Banner Elementary School administer the above medication to my child in accordance with my request and the physician's statement of need. I agree to notify the school in writing of any changes in my child's condition with respect to the administration of medication or with any changes to the information provided on this form.

I understand that it is my responsibility to send an appropriate supply of medication to school in its original container. Medication provided to the school in any container other than the original will not be accepted. I understand that the school will have limited liability while administering medication to my child in accordance with a physician's statement of need.

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date

**This form must be signed by a physician and a parent in order for Banner Elementary School to administer any medication (even over the counter) to your child.**

**Physician Statement of Need**  
(to be completed by attending doctor)

Student's Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
Student's Address \_\_\_\_\_ Grade \_\_\_\_\_

Medication to be administered \_\_\_\_\_  
Does this medication have a generic name also? \_\_\_\_\_  
Time or interval at which each dosage is to be administered \_\_\_\_\_

Date to begin administration \_\_\_\_\_  
Date to cease administration \_\_\_\_\_

Possible adverse reactions \_\_\_\_\_  
\_\_\_\_\_

List of severe reactions that should be reported to the physician \_\_\_\_\_  
\_\_\_\_\_

Special instructions for storage of medication \_\_\_\_\_

Special instructions for administration of medication \_\_\_\_\_  
\_\_\_\_\_

Physician's name \_\_\_\_\_

Physician's address \_\_\_\_\_

Physician's phone \_\_\_\_\_

Emergency contact information for physician \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Physician's Signature Date