MEDICATION ADMINISTRATION REQUEST

DATE ________________________

Name of Student ____

Date of Birth ________________________________ Grade _________________________

School _____________________________________ Homeroom _____________________

I have sent the following medicine in its original, unopened container for my child to receive during school hours. I understand the medication request and dosage must be appropriate for my child's age, or I will have to obtain a written order from our physician or dentist. I will not hold the school responsible for any allergic reaction that may occur.

Medication ____

Route __________________________________ Indication for Use _________________________

Dosage _________________________________ Frequency ______________________________

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Parent or Legal Guardian Signature