

PARENT REQUEST FOR ADMINISTRATION OF MEDICATION TO A STUDENT

Name of Student	Birth Date	ID Number
Address	Telephone	Zip Code
Igive permission to the school staff to a		n) of the above named student, my child's health care provider
(name of physician)	during school hours.	
I will bring the medication to school by the pharmacist or licensed provider		iginal container appropriately labeled
Signature of Parent / Guardian		
Address		······································
City Zi	р	
Home Phone	Mobile Phone	Business Phone
Date		

*This request is valid for the current school year and must be resubmitted at the beginning of the academic year. Any change in medication or dose requires a new request form.