Request for Administration of Medication

Physician's signature is required for long-term prescribed medications, including "as needed" medications such as those used for asthma, and for over-the-counter medications given for more than 30 days. In addition, the school may request physician signature for any medication requiring additional monitoring.

To the director of_____ Date_____

Prescription medication must be in the original container with the student's name, doctor's name and current date and dose instructions. Non-prescription medication must also be in the original container and will be given according to label directions.The School is authorized to contact and consult with your child's physician regarding his/her medical needs.

(School name)

As parent/guardian of_____ Date of birth_____,

I,_____, give permission for a designee of CHANGEE

(Print parent's name)

Academy to administer to my child, the following medication:

Name of medication _____

Dose (amount) to be given_____ Concentration_____

Time to be given_____ Date to discontinue_____

Additional instructions or side effects regarding the above medication_____

_____

Reason for administering medication_____

Physician's name_____ Telephone No._____
(Include area code)

_____ _____

Physician's Signature Date

_____ (_____) _____ (_____) _____

Parent/Guardian Signature Work Telephone/ Home Telephone

Filed on_____ by_____

You may make additional copies of this sheet .