AURORA CITY SCHOOLS

REQUEST FOR ADMINISTRATION TO STUDENTS OF MEDICINES PRESCRIBED BY A PHYSICIAN

STUDENT'S NAME ____

Parent/Guardian Section

I am the parent, guardian, or person having care or charge of the above-named student. I request that the medication herein described be administered to him/her.

I shall present the medication in the container in which it was dispensed by the prescribing physician or a licensed pharmacist.

If any of the original information provided by the prescribing physician changes, I agree to submit a revised statement signed by the physician who prescribed the medication.

______________________________ ______________________
parent/guardian's signature date

______________________________ ______________________
home telephone number work telephone number

School Section

Medication received in original container by:

______________________________ ______________________
name date

Revised statement received by:

______________________________ ______________________
name date

Information checked by: ______________________________________

Medication administered by: __________________________________

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Notes: ____

____

Retention procedures by: ______________________________________

OVER

Physician's Section

All information must be provided before administration of medication may begin.

- ❑ Student/Patient Name ______________________________
- ❑ Address ______________________________
- ❑ School ______________________ ❑ Grade/Class __________
- ❑ Name of Medication ______________________________
- ❑ Dosage ______________________________
- ❑ Times/Intervals of Administration ______________________________
- ❑ Begin Administration (date) ______________________________
- ❑ End Administration (date) ______________________________
- ❑ Special Instructions for Administration (including sterile conditions, storage, etc.):

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- ❑ Severe reactions to be reported (in event of emergency) to:

______________________________ name ______________ telephone

______________________________ name ______________ telephone

______________________________ name ______________ telephone

- ❑ Name of Physician (please print): ______________________________
- ❑ ______________________________ Signature of Physician date ______________