PARIS UNION SCHOOL DISTRICT NO. 95

REQUEST FOR SCHOOL ADMINISTRATION OF MEDICATION

Student's Name_____ School_____

Age_____ Grade_____

TO BE COMPLETED BY PHYSICIAN:

Medication name/Dosage_____Time_____Route_____

Disease or illness of student_____

Action of drug_____

Side effects of drug_____

_____

Other Medications Child Is Receiving?_____

_____

To be given until what date?_____

_____ _____

Parent Signature Physician's Signature or Name

_____ _____

Date Physician Address

_____ _____

District Nurse Initials/Date Physician Phone Number

The above named medication is to be brought to school in a container appropriately labeled by the pharmacy or physician.

Your signature above gives the school permission to administer the prescribed medication to your child.