REQUEST FOR ADMINISTERING
PRESCRIBED MEDICATION TO A STUDENT

If your child requires more than 1 medication, please attach a separate request for each medication.

NAME OF CHILD: ....................................................................................

Name of prescribed medication: ................................................................................

Prescribed for (name of medical condition): .................................................................

Prescribed dosage: ......................................................................................................

Special storage requirements if any (e.g. in refrigerator)................................................

Special instructions for administering the prescribed medication. (e.g. must be taken with food or with a glass of water)........................................................................

Through information you have obtained from your doctor or acquired yourself, are you aware of any likely side effects from the prescribed medication?

YES ☐ NO ☐

If YES, please provide more information........................................................................

If your child administers his or her own medication at home, do you request that he or she self administers this medication at school?

YES ☐ NO ☐

If YES, the Principal needs to approve a decision for a student to self administer.

If your child self administers the medication at home, what level of support do you provide? ............................................................................................................................................

Name of person who will carry the medication to school......................................................

NAME of PARENT: .......................................................... ..................................................

DATE: ................................................................. Signature