

Student Name _____

Address _____

Date of Request _____

Teacher _____

Grade Level _____

**REQUEST FOR THE ADMINISTRATION
OF MEDICATION / TREATMENT
BY SCHOOL PERSONNEL
FORM 5330 F1**

A separate form must be completed for each medication.

MEDICATION / TREATMENT	Name and dosage of medication/procedure _____
	Purpose of medication/procedure _____
	Time/intervals medication/procedure is to be administered at school _____
	Possible side effects or adverse reactions which should be reported to the physician _____
	Special instructions, including storage and/or sterile requirements _____
	Date medication/procedure to begin _____
	Date medication/procedure no longer needed _____

This section must be completed for prescription medication only as required by state law.

AUTHORIZATION	<i>Physician's Signature</i> _____ <i>Date</i> _____
	<i>Typed Name of Physician</i> _____ <i>Telephone Number</i> _____
	<i>Physician's Address</i> _____
	This section must be completed by parent/guardian for prescribed and non-prescribed (over-the-counter) medications.
	I hereby request and give permission to authorized school personnel to administer the medication and/or procedure as instructed by the physician, and agree:
	<ul style="list-style-type: none"> • To deliver the medication to the school. • To notify the school if the medication, dosage, or the procedure is changed or to be eliminated. • To allow communication between school nurse and physician in regards to administration of medication.
<i>Signature of Parent/Guardian</i> _____ <i>Date</i> _____	
<i>Daytime Telephone Number</i> _____ <i>Home Telephone Number</i> _____	

