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EPISCOPAL HIGH SCHOOL

Request for Administration of Medicine by School Personnel

Student Name | Date of Birth

MEDICATION	DATE OF REQUEST
DOSAGE	DATE OF TERMINATION

METHOD OF ADMINISTRATION **& TIME OF DAY TO ADMINISTER**

CONDITION FOR WHICH DRUG IS GIVEN:

POSSIBLE REACTIONS OR REACTIONS WHICH SHOULD BE REPORTED TO PHYSICIAN:

DISPOSITION OF STUDENT FOLLOWING ADMINISTRATION OF MEDICATION (e.g., rest, return to class, go home, send to hospital or doctor's office, etc.):

THIS FORM MUST ACCOMPANY MEDICATION BROUGHT TO THE SCHOOL. THE ABOVE MEDICATION CANNOT BE SCHEDULED FOR OTHER THAN SCHOOL HOURS. THE ABOVE MEDICATION MAY BE ADMINISTERED BY A MEDICALLY UNTRAINED DESIGNEE OF THE SCHOOL NURSE.

Parent Signature | Date

Physician Signature | Date