EDGEWOOD INDEPENDENT SCHOOL DISTRICT

Parent / Physician Request for
Administration of Medication by School Personnel

Student's Name: _____ Date: _____

School: _____ Teacher / Grade: _____

Name of Medication: _____ Dosage: _____

Condition for which medication is required: _____

Date(s) & Time(s) to be administered: _____

*****May administer morning dose of medication if not taken at home (please circle): Yes No**

*****Medication to be administered on early release days (please circle): Yes No**

Special Instructions / Side Effects of medication for your child: _____

_____

Physician's Name: _____ Phone: _____

*Physician's Signature: _____

Physician's signature is required to administer over-the-counter medications for more than 10 consecutive school days from the date of the original request

My signature below indicates that I request EISD staff to administer the medication specified above to my child, and I am giving permission for EISD staff to contact the physician for additional information if needed.

****Parent / Guardian Signature:** _____

Home Phone: _____ Other Phone: _____

Email (optional): _____

**** FOR OFFICE USE ONLY ****					
Date	Medication Received	Initials	Date	Medication Received	Initials
Date	Comments				Initials