

Parent/Physician Request for Administration of Medication by School Personnel

Date of Request: _____

Student's Name: _____ Birth date: ____/____/____

Medication: _____ Exp. Date: ____/____

Dosage: _____

Route of administration:

☐ by mouth ☐ inhaled ☐ topical ☐ eye(s) ☐ ear(s) ☐ nasal ☐ other: _____

Time to be administered: _____ Dates to be administered: _____

Condition for which medication is required: _____

Has your child ever taken this medication before: Yes No

Medication Allergies: ☐ No Known Medication Allergies ☐ Allergic to: _____Special Instructions/Precautions/Side Effects of medication on your child: _____

Physician's Name: _____ Phone (_____) _____ - _____

Physician's Signature: _____

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

Parent/Guardian Signature: _____

Email: _____

Parent's Daytime Phone: (_____) _____ - _____

Parent's Cell Phone: (_____) _____ - _____

Please use separate form for each medication.

Bring Request Form & Medication in Ziploc Bag labelled with student's name to the school office.