ST. MARY SCHOOL **Health Services**
515 Beall Avenue
Wooster, Ohio 44691
Phone (330) 262-8671 Fax (330) 262-0967

PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL
(MUST be completed for prescription medications)

_____ is under my care and should receive

_____ (Name of Drug, Dosage, Route)

At the following times: _____.

Specific Instruction for Administration: _____

Possible Side Effects: _____

Expiration Date of This Request: _____

Physician's Signature_____

Address: _____

Phone: _____ Date: _____

_____

PARENT'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL
(MUST be completed for all medications)

"I hereby request and give my permission to the principal or other responsible staff member to administer the following medication to my child":

Name of Pupil: _____

Name of Medication: _____

Dosage: _____

Expiration Date of This Request: _____

Parent's Signature _____

Date: _____