DANVILLE SCHOOL DISTRICT # 118
REQUEST FOR ADMINISTRATION OF MEDICATION

Part 1 - To be completed by a licensed prescriber which includes: Physician, Dentist, Podiatrist, Optometrist, Physician Assistant or Advanced Practice Nurse.

Name of Student: _____ Birthdate _____

1. Name of Medication: _____

   A. Dosage _____

   B. Route of Administration _____

   C. Frequency & time of administration _____

2. Diagnosis: _____

3. Other medications student is receiving: _____

4. Possible side effects: _____

5. Start Date _____ Stop Date _____

Licensed Prescriber (print) _____

Signature of Licensed Prescriber _____

Address _____

_____

Telephone _____ Date _____

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Part 11 - To be completed by the Parent or Legal Guardian

I _____ give permission for my child to receive the above medication as directed by the licensed prescriber. The medication will be sent to school in a container appropriately labeled by the pharmacist. I will provide the school nurse with a written note from the licensed prescriber if the medication is discontinued. Also, I will obtain a new doctor's order if there is a change in medication and /or dosage.

Date: _____ Parent/Legal Guardian _____

Address _____

_____

Telephone (Home) _____

(Work) _____