

**Daily Medication Administration Request**

**2015-2016**

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Allergies: \_\_\_\_\_

Date of Request: \_\_\_\_\_

Medication	Dose (ml,tsp,etc)	Time to be given	Reason why	Side Effects or Special Notes

I, the undersigned parent/guardian of \_\_\_\_\_ request the above medication(s) be administered to my child as requested above by the school nurse. I also give permission to my child's teacher or administration to administer the same medication as prescribed above in the absence of the nurse and on field trips during the school year. This medication has been prescribed by a licensed physician. I hereby release Allen Academy and its employees from any and all liability that may result from my child taking the above medication(s).

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Prescribing Physician:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**\*A properly labeled, original prescription bottle is required and will stand as physician signature.**

**\*Student must have taken at least one dose of this medication at home prior to administration at school.**