St. Teresa of Avila School

1194 Rulison Avenue
Cincinnati, OH 45238
Phone: 471-4530 Fax: 471-1254

PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

_____ is under my care and should receive

_____ at the following times _____
Name of drug, dosage, route

Specific instructions for administration: _____

Possible side effects to watch for: _____

Expiration date of this request: _____

Date: _____ Physician's Signature: _____

Physician's Phone Number: _____

PARENT'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

I hereby request and give my permission to the principal or his/her delegate (school nurse or other responsible person) to administer the following medication to my child.

Name of Student: _____

Name of Medication: _____ Dosage/Route: _____

at the following time(s): _____

Date: _____ Signature of Parent/Guardian: _____