REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Albany County School District #1
Laramie, Wy 82070

NAME OF CHILD _____ SCHOOL _____

DATE OF BIRTH _____ GRADE _____

TO BE COMPLETED BY PHYSICIAN:

DIAGNOSIS: _____

RX: _____

_____
Dosage, Frequency, and times to be taken at school

REPORTABLE ADVERSE REACTIONS: _____

BEGINNING DATE: _____ **ENDING DATE:** _____

OTHER MEDS CURRENTLY TAKEN: _____

NAME OF PRESCRIBING PHYSICIAN: _____

PHYSICIAN'S SIGNATURE: _____ **DATE** _____

I request that this medication be given to my child as directed above, only under the supervision of designated school personnel. I authorize the release of information between the school and physician pertinent to my child's medication.

_____ _____ _____ _____
signature of **parent/guardian** date signed phone # emergency #

approved by: _____ _____ _____
school nurse principal date