WARREN CONSOLIDATED SCHOOL

School: _____ Date: _____
School Phone: _____
School Fax: _____
Student: _____

REQUEST FOR ADMINISTRATION OF PRESCRIBED AND/OR OVER THE COUNTER MEDICATION/HEALTH PROCEDURE TO STUDENT

Dear Parent/Guardian:
Under certain conditions, as a service to you for the welfare of your child, parental requests for the in-school administration of necessary prescribed and/or over-the-counter medication/health procedures will be honored.

A written statement signed and dated by the attending physician, supporting this parent/guardian request, is required. The physician's statement must also provide clear directions for administering the medication or health procedure in school.

TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN:

As indicated by the prescribing physician below, I do hereby request and authorize that the prescribed and/or over-the-counter medication/health procedure be administered to:

STUDENT'S NAME: _____ GRADE: ____ DATE of BIRTH: _____
SIGNATURE OF PARENT OR LEGAL GUARDIAN: _____DATE_____

ADDRESS: _____

HOME PHONE: _____ MOBILE PHONE _____ WORK PHONE: _____

TO BE COMPLETED BY THE PHYSICIAN

I recommend that prescribed and/or over-the-counter medication/health procedure listed below be administered to:
STUDENT'S NAME: _____DIAGNOSIS: _____

NAME OF MEDICATION/PROCEDURE:_____

DOSAGE:_____TIME/FREQUENCY: _____

ROUTE OF ADMINISTRATION:_____

FIRST DATE OF MEDICATION:_____LAST DATE OF MEDICATION:_____

ADDITIONAL DIRECTIONS/PRECAUTIONS: _____

_____

PHYSICIAN'S SIGNATURE:_____DATE:_____PHONE_____

ADDRESS _____PHYSICIAN PRINTED NAME_____

(Imprint Physician's office stamp here)