PARENT/GUARDIAN
REQUEST TO ADMINISTER MEDICATION IN SCHOOL

_____
Name Grade Room

Please administer prescribed medication to our child according the Physician Medication Instructions.

As a parent/guardian of _____, we have read the Guidelines and we hereby release the Fox Chapel Area School District and all its employees from all liability for damages our child may suffer as a result of this request.

_____ _____
Date Signature of Parent/Guardian

PHYSICIAN'S MEDICATION INSTRUCTIONS

The parent/guardian has requested that medication be administered during the school day. If you feel it essential that the medications(s) be administered during the school day, we require completion of the information below.
Diagnosis_____

_____
Medication Dosage Administration Time

_____
Medication Dosage Administration Time

_____
Medication Dosage Administration Time

May carry inhaler: Yes_____ No_____

Self-administer: _____with _____without adult supervision.

Possible side effects_____
Curtailment of school activity (sports, shop, labs, etc.) _____

_____
Duration: From_____/_____/_____to_____/_____/_____
Month Day Year Month Day Year

Other medications student is taking outside school hours_____

_____
Comments_____

_____

_____
Date Physician's Signature Telephone Number