PARENT/GUARDIAN
REQUEST TO ADMINISTER MEDICATION IN SCHOOL

Name
Grade
Room

Please administer prescribed medication to our child according to 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________________________________________________________

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Administration</th>
<th>Time</th>
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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 ______/______/____

Other medications student is taking outside school hours________________________

Comments__________________________________________________________

________________________________________________________

________________________  __________________________
Date  Physician’s Signature  Telephone Number