Madison School District 321
STUDENTS **3510F**

PHYSICIAN'S AND PARENTS' REQUEST FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

1. Name of Pupil _____ Birthdate _____

2. Address _____ Grade _____ Teacher _____

3. Parent/Guardian Name_____ Phone_____

4. Physical condition for which drug is to be given. (If allergic in nature, please specify what type of reaction and indicate in detail those visible symptoms which would give rise to the necessity of administering the medication.)

_____

5. Medication_____

6. Dosage and Method of Administration_____

_____

7. Possible reactions that need to be reported to the physician

_____

8. Disposition of pupil following administration of medication, i.e., rest, home, hospital, doctor's office, return to class.

_____

The above medication cannot be scheduled for other than during school hours and such medication may be administered by medically untrained school personnel whenever necessary.

9. Date of Request _____

10. Medication to continue as above until (date)_____

11. PHYSICIAN'S SIGNATURE _____

12. Address _____ Phone _____

PARENT'S SIGNATURE _____Date_____

PRINCIPAL'S SIGNATURE _____ Date_____