BUF Health and Human Services

Sondra R. Clark, President & CEO

PHYSICIAN REQUEST FOR ADMINISTRATION OF MEDICATION IN SCHOOL

Re: Name of child ______________________ **Birth date** ______________

In order to keep this child in optimum health and to help maintain maximum school performance, it is necessary that medication be given during school hours.

Name of medication ______________________

Route (Oral, injection, etc.) ______________________

Diagnosis ______________________ Dosage ______________

Length of time prescribed ____________ Time ______________

The parent/guardian is aware of this request and is in full agreement that this medication will be supplied as needed. Should the student manifest any of the following symptoms caused by the medication, please contact the parent/guardian or my office.

Side effects: ______________________________________

Remarks: ______________________________________

Medication order for Class trip days: ______ Dose may be omitted

______ Schedule may be adjusted

____

(Please specify adjusted schedule)

____
Physician's Signature

______________________ ______________________
Telephone Date

This is your permission to give medication to my child named above as requested by the physician.

______________________ ______________________
Signature of Parent/Guardian Telephone Number

____
Date

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