New Albany – Floyd County Consolidated School Corporation
School Health Services

Request For Administration of Medication

Student's Name_____/School_____

Teacher_____/Grade_____

Please administer to the student named above the following medication:

Name of Medication_____

Dosage _____

Time to be given _____

It is understood that the medication is to be furnished to the school by the parent or guardian on a daily dosage basis. Over-the-counter medication must be provided in its original container. Prescription medication is to be furnished by the pharmacy in a container labeled by the pharmacy with the following information:

Prescription Number
Doctor's Name
Child's Name
Dosage
Time to be given

Unless other arrangements are made, I give the school permission to send home medication that has been in its possession with my child at the end of the school year.

_____ _____
Parent or Guardian's Signature **Date**

_____ _____ _____
Doctor's Printed Name **Doctor's Phone Number** **Doctor's Fax Number**

_____ _____
Doctor's Signature **Date**

8/79
Reviewed 2003, 2004, 2010

THIS FORM MUST BE RENEWED AT THE BEGINNING OF EACH SCHOOL YEAR