SUMTER COUNTY SCHOOLS

STUDENT HEALTH SERVICES

PHYSICIAN'S REQUEST FOR ADMINISTRATION OF MEDICATION
IN SCHOOL BUILDING DURING SCHOOL HOURS
Must be Completed Annually

1. To keep this child in optimal health and to help maintain school performance, it is necessary that medication be given during school hours.
2. Nurses and other designated school personnel can assist with self-administration of medication during school hours.
3. In order for medication to be self-administered at school, this form must be completed by licensed physician and at least one guardian/parent and be returned to school.

School: _____

Name of child: _____ DOB: _____

Diagnosis: _____ Please check one: Infectious ___Noninfectious_____

Allergies: _____

Name of Medication (Include trade name): _____ Color (If applicable): _____

Route of Administration: _____

Form of medication to be given (specify below):
Tablet _____ Pill _____ Capsule _____ Liquid _____ Inhalation _____ Injection**_____ Other _____
****No injection will be given except in extreme emergency, such as allergy to wasp or bee sting or the like.**

Dosage (amount to be given): _____ Frequency: _____

Side Effects: _____

_____ _____
Physician's Name (print or type) Physician's Signature Date

_____
Physician's Office Name/Phone #/Fax#

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

_____
Parent/Guardian Name(print) Contact Number

Parent Guardian Signature Date