

Rev: 8/09 dm

REQUEST FOR ADMINISTRATION OF
PRESCRIPTION/NONPRESCRIPTION
MEDICATION



Student's Name _____

Grade/Teacher _____

Room Number _____

Date of Plan _____

Emergency Contact Information:

Mother/Guardian _____

Home phone: _____ Cell: _____ Work: _____

Father/Guardian _____

Home phone: _____ Cell: _____ Work: _____

For Parent/Guardian Completion:

I, _____ the parents of _____
Parent's Name Child's Name

authorize Anchor Bay schools to administer oral medication to my child according to the directions below:

Name of Medication: _____

Dose (including timing): _____

Condition/Purpose: _____

Parent/Guardian Signature: _____ **Date** _____

Physicians Signature: _____ **Date** _____

Physicians Address: _____ **Phone Number** _____

PROCEDURE FOR ADMINISTRATION OF MEDICATION:

1. All medication is to be brought to the school office by an adult.
2. Medication is to be in the original bottle.
3. Students are not to carry medication to school.
4. The building Principal will be responsible for developing the building procedure.
5. Prescribed medication must be in pre-measured form. School personnel must not be expected to measure liquids.
6. Please note, AB Schools cannot administer expired medications.