Form B.2 Physician Request for the Administration of Prescription Medication by School Personnel

(Physician and parent signatures required)

PRESCRIPTION MEDICATION

Columbus School for Girls

Student Name: _____ Entering Form: _____ Request expires: *End of school year or specific expiration date:* _____

Medications: (*Daily and occasional prescription medications to be given by school personnel, i.e., ADD/ADHD meds, migraine meds, etc.)*

1) _____

Name

Specific instructions for administration: _____

Dosage Route Dosage Schedule

Possible side effects and suggested actions if they occur: _____

2) _____

Name

Specific instructions for administration: _____

Dosage Route Dosage Schedule

Possible side effects and suggested actions if they occur: _____

3) _____

Name

Specific instructions for administration: _____

Dosage Route Dosage Schedule

Possible side effects and suggested actions if they occur: _____

4) _____

Name Dosage Route Dosage Schedule

Specific instructions for administration: _____

Possible side effects and suggested actions if they occur: _____

Additional information:

_____

_____

_____

Physician Name (print): _____ Phone: _____

Physician Signature: _____ Date: _____

Parent/Guardian:

I request that the drug prescribed by the physician be administered to the student. I agree to submit in writing a revised physician's statement in the event that any of the required information should change. I give permission for the principal or school nurse to contact the physician regarding the administration of this medication in the school setting. I agree to deliver the needed medication to the school in the original prescription container. I agree to pick up medication within three days of termination of administration of medication or end of school year, or school staff will dispose of medication.

Parent/Guardian Signature: _____ Date: _____