

**WILLARD CITY SCHOOLS
PHYSICIAN'S REQUEST FOR ADMINISTRATION
OF MEDICATION BY SCHOOL PERSONNEL**

_____ is under my care and should receive
Name of student

_____ at the following times
Name of drug, dosage, route

Specific instructions for administration:

Possible side effects to watch for:

Expiration date of this request:

Date:

Physician's signature

Physician's phone number

**PARENT'S REQUEST FOR ADMINISTRATION OF MEDICATION BY SCHOOL
PERSONNEL**

I hereby request and give my permission to the principal or his delegate (school nurse or other responsible person) to administer the following medication to my child.

Name of child

Name of drug

Dosage

Route

at the following time(s)

Date

Signature of Parent or Guardian