

**PHYSICIAN/PARENT REQUEST FOR ADMINISTRATION
OF MEDICINE BY SCHOOL PERSONNEL 2020-2021**

Prescribed medication is administered by a *non-health* professional designate of the Principal. This medication should be brought to school in **THE ORIGINAL CONTAINER** appropriately labeled by the pharmacy. Parents may request the pharmacist dispense two bottles of medication, one for home and one for school.

1. Name of Student _____ Birth Date _____
2. Condition for which prescribed treatment is required: _____
3. Specific medications(s): _____

4. Dosage & method of administration (include time schedule) _____

5. Precautions, unfavorable reactions: _____

6. Date of Request: _____ Date of Termination: _____
7. Physician's Name (Print): _____
Physician's Signature: _____
Address: _____
City, State and Zip: _____
Phone Number: _____

I understand that by signing this form I release the school from all liability associated with the dispensing of this medication.

Notre Dame School has permission to administer following non-prescription medications to my student. ***I will furnish a small bottle with my student's name on it and written instructions.***

____ Tylenol

____ Advil

____ **NO** permission granted for Over The Counter Medications

Parent/Guardian Signature: _____