FLORENCE TOWNSHIP SCHOOL DISTRICT

Request for Medication Administration

1. **Physician's Authorization:**
   Please administer to _____

   Medication _____

   Dosage_____ Time _____

   Reason_____

   Possible adverse reactions _____

   Physician's Signature with Stamp_____

   Date_____

2. **Parent/Guardian Authorization:**
   I, _____, request that the medication listed above be administered to my child at school. I understand that the school nurse or substitute school nurse will administer the medication. I will notify the school immediately if my child's health status changes or if there is a cancellation or change of this medication.

   Parent/Guardian Signature_____
   Date_____

3. All medication must be delivered to the school nurse by the parent or guardian in the original container provided by the pharmacy. Daily transportation of medication by the child ***is not permitted*** for safety reasons.