

**MSAD #52 REQUEST FOR ADMINISTRATION OF MEDICATION
IN SCHOOL**

Student's Name _____

Name of Medication _____

Health Care Provider's Name _____

Telephone Number _____

Reason for Medication

Dosage _____ Time to be administered _____

Duration of the medication

Other Directions

Possible side effects and steps to be taken in case of side effects

The undersigned parent or guardian of the above named student requests and authorizes the school nurse or other person designated by the school principal to administer the above described medication to his/her child.

In the case of an emergency medication I choose the following:
(Please check one) _____ I Request _____ I Do Not Request
that my child be permitted to carry his/her medication on his/her person at all times when being transported to and from school, when at school, or when involved with school activities. If I check "I Request", I will also submit a copy of the MSAD#52 Health Care Provider Permission Form For A Student To Carry Emergency Medication signed by my child's health care provider.

(Date)

(Parent/Guardian Signature)