



Parent/Physician Request for Administration of Medication by School Personnel

Date of Request: _____ School: _____ Teacher/Grade: _____

Student's Name: _____ Birth date: _____

Medication: _____ Exp. Date _____ Dosage: _____

Is this the initial dose of a new medication that has not been previously administered to your child? YES NO

Time to be Administered: _____ Dates to be Administered: _____

Condition for which medication is required: _____

Special Instructions/Precautions/Side Effects of medication on your child: _____

Physician's Name: _____ Phone: _____

*Physician's Signature: _____

My signature below indicates that I request that RISD staff administer the medication specified above to my child, and I am giving permission for RISD staff to contact the physician for additional information, if needed.

Parent/Guardian Signature: _____ Email: _____

Parent's Daytime Phone: _____ Cell Phone: _____

**Physician's signature is required to administer over-the-counter medications for more than 10 consecutive school days from the date of the original request.*

Only a 30-day supply of medication will be accepted at a time.

FOR OFFICE USE ONLY!

- Entered in Star Student
- Teacher Notified ___/___

Medication Count:

Date	# Pills	Counter's Signature	Witness Initials	Date	# Pills	Counter's Signature	Witness Initials

Comments (Indicated by * on back of form):

Date	Comments	Date	Comments

Date	RN Review

Medication returned to: Parent / Student _____ Date _____
Print Signature

STUDENT'S NAME: _____

MEDICATION: _____ DOSAGE: _____ TIME: _____

DAY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	DAY
1												1
2												2
3												3
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DAY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	DAY

CHARTING CODES

A	DC	FT	H	OOM	R	SF	*
Absent	Discontinued	Field Trip	Hold	Out of Medication	REACH	Sent For	Comments

* Indicates Comments on front of form