

DALLAS SCHOOL DISTRICT  
PO BOX 2010  
DALLAS, PENNSYLVANIA 18612

**REQUEST FOR ADMINISTRATION OF MEDICATION**

**TO the PHYSICIAN:**

School policy permits selected school personnel to administer medication to children who require medication during the school day. This procedure will permit the child to remain in school. All medication received by the school must be packaged according to current pharmacy standards. The following information is **required:**

Name of Child \_\_\_\_\_

School \_\_\_\_\_

Diagnosis \_\_\_\_\_

Medication Requires / Dosage / Duration \_\_\_\_\_

\_\_\_\_\_

Instruction for Administration / Time \_\_\_\_\_

\_\_\_\_\_

Possible Side Effects \_\_\_\_\_

\_\_\_\_\_

Signature of Physician \_\_\_\_\_ Telephone \_\_\_\_\_

Print Name of Physician \_\_\_\_\_ Date \_\_\_\_\_

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**To the Parent:**

I authorize selected school personnel to administer the above medication as prescribed. This authorization specifically releases the Dallas School District and all its agents and employees from any and all liability and claim whatsoever arising from the administration of the above medication to my child.

\_\_\_\_\_  
Printed Name of Father / Mother                      Home Phone                      Work Phone

\_\_\_\_\_  
Signature of Father / Mother / Guardian                      Date

\_\_\_\_\_  
Signature of Child (Over 18)

.....  
**For School Health Services Use Only:**

\_\_\_\_\_  
Date Received                      Date Medication Started

\_\_\_\_\_  
School Nurse                      Date Medication Completed