

**AVON GROVE SCHOOL DISTRICT**

**PARENT/PHYSICIAN REQUEST FOR ADMINISTRATION OF MEDICATION**

STUDENT NAME \_\_\_\_\_ GRADE \_\_\_\_\_ HR \_\_\_\_\_

PARENT/GUARDIAN \_\_\_\_\_ PHONE # \_\_\_\_\_

HEALTH CARE PROVIDER \_\_\_\_\_ PHONE # \_\_\_\_\_

DIAGNOSIS OR CONDITION \_\_\_\_\_

MEDICATION \_\_\_\_\_ DOSAGE \_\_\_\_\_

TIME \_\_\_\_\_ ROUTE \_\_\_\_\_

MEDICATION \_\_\_\_\_ DOSAGE \_\_\_\_\_

TIME \_\_\_\_\_ ROUTE \_\_\_\_\_

MEDICATION \_\_\_\_\_ DOSAGE \_\_\_\_\_

TIME \_\_\_\_\_ ROUTE \_\_\_\_\_

DURATION OF ORDER \_\_\_\_\_

SPECIAL INSTRUCTIONS \_\_\_\_\_

IS STUDENT CAPABLE OF SELF-ADMINISTRATION? YES \_\_\_\_\_ NO \_\_\_\_\_

DOES STUDENT REQUIRE MEDICATION ON FIELD TRIPS? YES \_\_\_\_\_ NO \_\_\_\_\_

ADDITIONAL PERTINENT INFORMATION \_\_\_\_\_

HEALTH CARE PROVIDER SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

SCHOOL NURSE SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_