St. Joseph the Provider School
1125 Turin Ave.
Youngstown, OH 44510
Telephone – 330-259-0353
Fax – 330-259-0364

Physician's Request for the Administration of Medication by School Personnel

Name____ Grade______ Age_____

Address____

____ is under my care and should receive

____ at the following times____________
Name of Drug(s) Dose

Specific Instructions for Administration____

____

Possible Side Effects to Watch For____

Expiration Date of This Request____

Date Ordered____

Date Started____

____
Physician's Signature

Parent's Request for the Administration of Medication by School Personnel

I hereby request and give my permission to the principal or her delegates (school nurse or other responsible person) to administer the following medication to my child.

Name of Child_______________________________________

Name of Drug_________________ Dosage___________ Route_________________at the

Following time(s) ____

Date_________________ ____
Signature of Parent