St. Brigid of Kildare School
Dublin, Ohio

REQUEST TO ADMINISTER MEDICATION TO A STUDENT DURING SCHOOL HOURS

This will serve as an official request and permission for a designate of the school to dispense the below mentioned medication to my child during school hours as described below.

_____ _____
Parent/Guardian Signature **Date**

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This section to be completed by prescribing physician and/or parent:

Child's Name _____ Date of Birth _____
Address _____ Teacher _____

Medication _____ Dose _____

Time to be administered at school _____

Start date _____ Stop date _____

Special administration instructions _____
_____

Possible reaction to be reported to physician/parent _____
_____

_____ _____ _____
Physician Signature* Phone Date
*Physician signature required for all prescription medications.