

# CRESTWOOD LOCAL SCHOOLS

## PARENT/GUARDIAN REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

Student's Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

I agree to:

- 1) Return to school – Parent/Guardian Request Form.
- 2) Return to school – Physician's Request Form (reverse side).
- 3) Deliver the medication to school in its original container.
- 4) Notify the school if the student's physician is changed.
- 5) Written notification to the school by the student's physician if the medication, dosage, or procedure is changed.
- 6) Crestwood Local Schools and/or employees designated to administer medication will not be liable.

\_\_\_\_\_  
(Signature of Parent/Guardian)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City/State/Zip)

(\_\_\_\_\_) \_\_\_\_\_  
(Telephone)

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### **For School Use Only**

Persons authorized to administer medication: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Approved by: \_\_\_\_\_

(Signature of Principal)

(Date)

Designee: \_\_\_\_\_

Building: \_\_\_\_\_

# CRESTWOOD LOCAL SCHOOLS

## PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

Student's Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Address: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

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\_\_\_\_\_ is under my care and should receive  
(Student's name)

\_\_\_\_\_ at the following times:  
(Name of Drug, Dosage, Route)

\_\_\_\_\_

Specific instructions for administration: \_\_\_\_\_

\_\_\_\_\_

**Self-medicate instructions:** \_\_\_\_\_

\_\_\_\_\_

Starting date of this request: \_\_\_\_\_

Expiration date of this request: \_\_\_\_\_

\_\_\_\_\_  
(Physician's Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Physician's Name-Printed or Typed)

\_\_\_\_\_  
(Physician's Address)

\_\_\_\_\_  
(Physician's Telephone Number)