



ST. VINCENT FERRER SCHOOL

7754 Montgomery Road
Cincinnati, Ohio 45236
(513) 791-6320

REQUEST FOR THE ADMINISTRATION OF MEDICATION

BY SCHOOL PERSONNEL: PHYSICIAN

_____ is under my care and should receive
Name of Student

_____ at the following times _____
Name of Drug, Dosage, Route

Specific instructions for administration _____

Possible side effects to watch for _____

Date _____

Physician/Es Signature

Physician/Es Phone Number

REQUEST FOR THE ADMINISTRATION OF MEDICATION

BY SCHOOL PERSONNEL: PARENT

I hereby request and give my permission to the principal or his delegate (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 or Guardian

