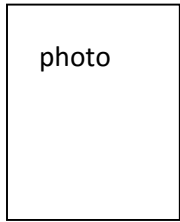


## AP 328-1 Request for Administration of Medication at School

A. (STUDENT NAME) \_\_\_\_\_  
Surname Given Name



B. TO BE COMPLETED BY PRESCRIBING PHYSICIAN (Condition(s), which make medication necessary)

Name of Medication	Dosage	Directions for Use
1.		
2.		
3.		
4.		

(Additional comments – possible reactions, consequences of missing medication, etc.)

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

C. TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN

I request the school to give medications as prescribed on this form to my child whose name is recorded below

I will notify the school promptly of any changes in medications ordered

\_\_\_\_\_  
Name of Child

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date

D. Each School Staff Member who is responsible for the administration or supervising of the medication must review the information on this form, then date and sign below.

Date	Signature	Comments