

ASHLAND CITY SCHOOLS  
PHYSICIAN'S REQUEST  
FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

Student's name \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Student's address \_\_\_\_\_

\_\_\_\_\_ is under my care for \_\_\_\_\_  
(Name of student) (Purpose of medication)

and should receive the following medication:

<u>DRUG</u>	<u>DOSAGE</u>	<u>TIME</u>	<u>ROUTE</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Specific instructions for administration

Possible side effects to watch for

Expiration of this request \_\_\_\_\_

Date \_\_\_\_\_

\_\_\_\_\_  
(Physician's signature)

Phone number \_\_\_\_\_

FAX number \_\_\_\_\_

Date \_\_\_\_\_

\_\_\_\_\_  
(Parent's signature)

No employee who is authorized by the Board of Education to administer a prescribed drug and who has a copy of the most recent physician's statement will be liable to civil damage arising from the administering or failure to administer the drug, unless the employee acted in a manner that would constitute negligence or misconduct.