Sycamore Springs Elementary School
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Medication Administration Request Form

When it is necessary for your child to receive medication during the school day (please see DSISD Student Handbook for guidelines), the following procedures **must** be followed:

1. Parents/guardians must provide all medication and parent/guardian signature is required for all medications given at school. **A US-licensed physician's signature is required for all prescription and OTC medications for the 20-21 school year. A physician's signature is also required for medications prescribed differently from manufacturer's instructions.**
2. All medication must be in the original container & clearly labeled with the student's name, dosage, & directions for administration. **All medications must be hand-delivered to the school nurse by the parent/guardian or their representative age 21+.**
3. The Medication Administration Request Form must be completed each school year ***and*** when there are any changes to the original request including, but not limited to, medication and/or dose change. A separate form must be completed for each medication.
4. Only FDA approved pharmaceuticals will be administered. No homeopathic preparations, herbals, home remedies, or dietary supplements will be accepted nor administered by any school personnel.
5. Parents/guardians are strongly encouraged to pick up all medication after it is discontinued. All unclaimed medication will be destroyed at the end of the school year.

I, _____, request and give permission for school personnel at Sycamore Springs Elementary School to give my child, _____, the following medication according to the stated directions. I understand and agree that the school will not be held responsible for any ill effects which might occur in connection with the administration of this medication.

Medication:	Dosage:	Diagnosis/Reason:
Drug allergies:	To be given from: _____ to:_____	
Parent/guardian signature:		Date:

Physician Orders For Medication

Medication:	Dosage:	Route:
School administration time:		Diagnosis:
Start (please check): _____ Date form received _____ Other, as specified: _____		End: _____ End of school year _____ Other, as specified:_____
Physician signature:		**Date:**
Physician Name (please print):		Phone: