AP 650 FORM: ADMINISTRATION OF PRESCRIBED MEDICATION

Student: _____ Grade: _____ School: _____

Parent/Guardian:_____

Cell Phone: _____ Work Phone: _____

Parent/Guardian:_____

Cell Phone: _____ Work Phone: _____

REQUEST AND AUTHORIZATION

I/We (Print name(s)), _____

hereby request and authorize the administration of the following prescribed medication

for my/our child _____

by non-medically trained staff at _____ school.

Name of student's pharmacist: _____ Phone:_____

Medication	Dosage/Timing	Side Effect

AP 650 FORM: ADMINISTRATION OF PRESCRIBED MEDICATION

Please state the duration of time to be covered by this parental and doctor's authorization (not to extend beyond the current school year): _____

Name of student's doctor: _____ Phone: _____

Doctor's signature: _____ Date: _____

Parent/Guardian's signature: _____ Date: _____

Parent/Guardian's signature: _____ Date: _____

Principal's signature: _____ Date: _____

Other pertinent information: _____

_____

Note:

1. Families/Agencies are required to contact the Principal of the school if there is a change in medication and/or dosage.
2. A unit dosage system must be utilized.
3. This form is to be completed in quadruplicate (4 copies) with one copy for each of the following:
    a. School
    b. Family/Agency
    c. Doctor
    d. Pharmacist
4. It is expected that only the daily requirement will be sent to school unless other arrangements are made with the Principal.