



"To Teach, To Nurture, To Serve"

Physician: _____

FAX: _____

- Ironton Elementary School (740)532-3077 (Fax)
- Ironton Middle School (740)532-3077 (Fax)
- Ironton High School (740)533-6027 (Fax)

Physician Request for the Administration of Medication by School Personnel

_____ is under my care for _____
Student's Name Diagnosis

and should receive _____
Name of Medication Dosage and route at the following times

Specific instructions for administration _____

Possible side effects _____

Expiration date of this request: _____

Physician Name: _____ Phone Number: (____) _____
(Please Print)

Physician's Address _____

Physician Signature _____ Date: _____

Parent's Request for the Administration of Medication by School Personnel

I hereby request and give permission to the principal or his/her designee to administer the following medication to my child and permission to share any medical information with the physician on their behalf.

Name of child _____ Name of Medication _____

Dosage _____ Route _____ Times _____

Parent Signature _____ Date: _____

Nurse Signature _____ Date: _____

Principal Signature _____ Date: _____

Case Notes: _____

