Fremont County School District No. 21 90 Ethete Road · Fort Washakie, Wyoming 82514 Phone: 332-2380 · Fax#332-3597

Request for Administration of Medication at School

Name of child:			DOB:	Grade:	*
	COMPLETED BY PHYS				
	DIAGNOSIS:				
	RX:				
	Dosage, Frequency, Route				
	REPORTABLE ADVERSE REACTIONS/SIDE EFFECTS:				
	Beginning Date: Ending Date:				
List other medications currently being taken: List any medication allergy: Name of Prescribing Physician:					
	Physician's Signature:	14	e	Date:	
I request that the Nurse or Principal's Designee administer the medication as directed above. <u>I understand that it</u> is my child's responsibility to report to the office for this service. I authorize the release of information between the school and physician pertinent to my child's medication.					
Signature	e of Parent/Guardian	Date Sig	gned Phone	Emerge	ncy#
Inhaler that he/sh	Exception: My child has be not be permitted to carry the in	en instructed in that haler and self adm	e proper use of the a		nhaler. I request
Signature of Parent/Guardian Date					
~~~~	T NOTE: NT MEDICATION MUST E	E IN THE PRES	ECRIPTION OR L	MANUFACTUR	ES CONTAINER.
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