

**Downingtown Area School District
Parent /Doctor Request for Administration of
Medication**

According to the State Board of Nursing, no medication can be administered in school except by written request of a physician.

According to DASD medication guidelines, **a physician authorization is required for administration of prescription medication and over the counter medications not on the approved list.** (Please see approved list on the other side of this form.) Any non-prescription medication will not be administered for more than five (5) consecutive days.

NAME OF PUPIL _____
GRADE/HOMEROOM TEACHER _____
DIAGNOSIS OR CONDITION FOR WHICH MEDICINE IS PRESCRIBED _____

MEDICINE PRESCRIBED _____

AMOUNT TO BE GIVEN _____

TIME MEDICINE IS TO BE GIVEN _____

DATE TO START MEDICINE _____

DATE TO STOP MEDICINE _____

*In the event of a **2 hour late opening** please advise regarding medication administration. Please check below:

_____ please **give medication @ normal time** at school.
_____ will be given later @ home **please give medication at school** at
_____ (time of day)

PARENT SIGNATURE

PHYSICIAN SIGNATURE

PARENT NAME/PHONE #

PHYSICIAN NAME/PHONE#