PARENTAL REQUEST AND PHYSICIAN'S ORDER FOR MEDICATION
(For students who require medication given by school personnel during school hours)

PARA SER LLENADO POR EL PADRE DE FAMILIA/TUTOR ENCARGADO: Fecha de Solicitud: _______

Nombre del Hijo: ___________________________ Fecha de Nacimiento: _________ Escuela: _____________

Solicito que se dará a mi hijo (anteriormente mencionado) el medicamento como se indica en la orden del médico a continuación. Soy consciente que el personal –el cual no es médico– administrará este medicamento a mi hijo. Por la presente libero a la administración de la escuela, sus representantes y sus empleados de cualquier y toda responsabilidad que pueda resultar cuando mi hijo tome el medicamento prescrito.

_____________________________	_____________________________	_____________________________
Nombre del Padre de Familia/Tutor Encargado (LETRA DE IMPRENTA)	Firma del Padre de Familia/Tutor Encargado	Teléfono(s) de Fácil Comunicación

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TO BE COMPLETED BY PHYSICIAN:

IT IS NECESSARY THAT THE ABOVED NAMED CHILD RECEIVE THE FOLLOWING MEDICATION DURING THE SCHOOL DAY. PLEASE ADMINISTER THE FOLLOWING AS DIRECTED BELOW:

Name and form of medication: ____

Dosage: ____________________________ Time(s) to Be Given: ____________________________________

Route of Administration: ____

Medical Diagnosis: ____

Other Specific Directions: ____

Side Effects to Watch for: ____

Duration of Order: ____

Is the student allowed to self-carry / self-administer? (Emergency medications only) ❑ **Yes** ❑ **No**

Physician's Signature: _______________________________________ Date: _____________________

Physician's Name and Address: ______________________________ Phone: _________________________
(Please print or use stamp)
______________________________ Fax: ___________________________

Reviewed by School Nurse ____________________________________ Date_________________________

Student Homeroom: ______________________________ Medication Expiration Date: _________________

PARENTAL REQUEST AND PHYSICIAN'S ORDER FOR MEDICATION

(For students who require medication given by school personnel during school hours)

YUAV TSUM YOG NIAM TXIV/TUS SAIB XYUAS UA KOM TIAV: Hnub Thov: ______________

Menyuam Npe: ___________________________ Hnub Yug: ___________ Tsev kawm ntawv: _________

Thov muab tshuaj noj rau kuv tus menyuam muaj npe saum no raws li tus kws kho mob tau hais kom noj hauv qab no. Kuv yeej paub hais tias tus yuav muab tshuaj rau kuv tus menyuam noj tsis yog ib tug neeg kho mob. Kuv muab kev tso cai rau tsev kawm ntawv cov neeg ua hauj lwm, lawv cov neeg sawv cev ntawm tagnrho cov los lav uas tej zaum yuav tsis pub kuv tus menyuam noj cov tshuaj kws kho mob muab no.

________________________________ ________________________________ ________________________________

Niam Txiv/Tus saib xyuas Npe (SAU) | Niam Txiv/Tus saib xyuas Kos Npe | Xov Tooj

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TO BE COMPLETED BY PHYSICIAN:

IT IS NECESSARY THAT THE ABOVED NAMED CHILD RECEIVE THE FOLLOWING MEDICATION DURING THE SCHOOL DAY. PLEASE ADMINISTER THE FOLLOWING AS DIRECTED BELOW:

Name and form of medication: ____

Dosage: ______________________________ Time(s) to Be Given: ______________________________________

Route of Administration: ____

Medical Diagnosis: ____

Other Specific Directions: ____

Side Effects to Watch for: ____

Duration of Order: ____

Is the student allowed to self-carry / self-administer? (Emergency medications only) ❑ **Yes** ❑ **No**

Physician's Signature: ____ Date: _______________________

Physician's Name and Address: _________________________________ Phone: ___________________________

(Please print or use stamp)

_________________________________ Fax: ______________________________

Reviewed by School Nurse _______________________________________ Date___________________________

Student Homeroom: _________________________________ Medication Expiration Date: __________________