



East Richland Christian Schools

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PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

_____ is currently under my care and should
(Student's name)

receive _____
(name of drug, dosage, route)

at the following times: _____

Specific instructions for administration: _____

Possible side effect(s) to watch for: _____

Expiration date of this request: _____

(Today's date)

(Physician's signature)

(Physician's phone number)

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PARENT'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

I hereby request and give my permission to the principal or his/her delegate (school nurse or other responsible person) to administer the following medication to my child:

Child's name: _____

Name of medication: _____ Dosage: _____

Route: _____

Given at the following times: _____

(Today's date)

(Parent/Guardian's signature)