CareerTech
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PRIVATE PHYSICIAN'S REQUEST FOR ADMINISTRATION OF PRESCRIPTION/NON-PRESCRIPTION MEDICATIONS DURING SCHOOL HOURS

Student's Name_____Date_____

Diagnosis_____

Name of Medication_____

Dosage_____

Duration of Medication Administration_____

Curtailment/Limitation of Normal School Activities:
(ex: sports, shop, driver's ed, lab, etc.) _____
_____

Student may carry inhaler at school _____Yes _____ No

_____ _____
Date Physician's Signature

_____ _____
Phone Physician's Name (printed)

I hereby grant permission to the Franklin County Career & Technology Center nurses to administer the above-mentioned prescription/non- prescription medication, as described, during school hours, to my child.

I also grant permission for the school nurse and prescribing doctor to share information regarding my child's health.

_____ _____
Date

Signature of Parent/Guardian