

CHRIST THE KING SCHOOL

PARENTAL REQUEST
FOR
ADMINISTRATION OF MEDICATION

Student's Name: _____

Parents/Guardians: _____

Address: _____
Street Zip

Phone: _____ Student's Age/Grade: _____

Physician: _____

Physician's Address: _____
Street Zip

Phone: _____

Reason for Medication: _____

Name of Medication: _____

Dates to be Administered: _____

Times and Amounts to be Administered:	Person Administering Medication:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Date of Request: _____

I HEREBY REQUEST THAT THE ABOVE MEDICATION BE ADMINISTERED AT THE TIMES INDICATED, IN THE SPECIFIED AMOUNTS TO MY CHILD, _____

Signature of Parent/Guardian

Signature of Physician