Att. A

LAKE COUNTY BOARD OF DD/DEEPWOOD
BROADMOOR SCHOOL
NURSING DEPARTMENT

PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION

(Including oral food supplements, modified diets or fluoride supplements)

_____ (Student Name) is under my care and should receive:

_____

(Name of Drug, Dosage, Route)

at the following times: _____

Specific instructions for administration:_____

Possible side effects to watch for:_____

_____

(Name of Drug, Dosage, Route)

at the following times: _____

Specific instructions for administration:_____

Possible side effects to watch for:_____

_____ _____

Physician Signature Date

Phone Number:_____

GUARDIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION

I hereby request and give consent to the principal or his/her designee (school nurse or other responsible person) to administer medication as above to my child.

_____ _____

Guardian Signature Date

***NOTE: This consent expires at the end of the current school year.**

ALL LINES MUST BE FILLED IN

THIS FORM MUST BE RETURNED TO BROADMOOR NURSING

Please feel free to contact Broadmoor Nursing at 440-602-1007 or 440-602-1054.

(08/2016)