



School Year \_\_\_\_\_

Grade \_\_\_\_\_

MADISON COUNTRY DAY SCHOOL  
Phone: 608-850-6000 Fax: 608-850-6006

REQUEST FOR ADMINISTERING **PRESCRIPTION MEDICINE**

**PHYSICIAN'S STATEMENT:** (Please state all instructions in language of lay person.)

I request that \_\_\_\_\_ receive the medication listed  
Child's Name

below for the period from \_\_\_\_\_ to \_\_\_\_\_ .  
Date Date

The medicine, which is to be furnished by the parent in the original container from the pharmacy, should include the child's name, physician's name, name of the drug, the dosage, the times of day to be given, and the name and telephone number of the pharmacy.

Name of Drug: \_\_\_\_\_

Dosage: \_\_\_\_\_

Time of Day to be Given: \_\_\_\_\_

Reason for Medication: \_\_\_\_\_

The following are specific conditions under which I should be contacted regarding the condition or reaction of the child receiving the medication:

\_\_\_\_\_  
\_\_\_\_\_

Physician's Signature: \_\_\_\_\_ (Print last name) \_\_\_\_\_

Date: \_\_\_\_\_ Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

**PATIENT'S STATEMENT:**

I request that my child \_\_\_\_\_ receive the above mentioned medication according to the physician's orders as stated above. I give my permission to school personnel to contact my child's physician. I also agree to provide a new medication form if there is any change in the above orders.

I further agree to hold Madison Country Day School and their authorized personnel harmless in any and all claims arising from the administration of this medicine.

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Daytime Telephone: \_\_\_\_\_