

**Wyoming Valley West School District
Private Physician Request For
Administration of Medication During School Hours**

Dear Doctor:

It is our procedure to request that medication be given before or after school hours whenever possible.

If it is essential that the student receive the medication(s) during school hours, please complete the following information:

Name of Medication(s) _____

Dosage _____

How to be administered (oral or injection) _____

Time schedule for administration _____

Duration of medication administration _____

If Epipen, Diastat or Inhaler, will the student be carrying it on their person?

Other medications prescribed by physician that student is taking outside of school hours _____

Is student capable of self administration with supervision? _____

Date

Physician's Signature

Physician's Phone Number

Print Physician's Name

Parent Consent Form For Prescription/Non Prescription Medication

We request that school personnel supervise the self administration of this prescribed/
non-prescribed medication to _____ according to
Student's Full Name
the above directions from our attending physician.

As parent/guardian of _____, we hereby release the
Wyoming Valley West School District and all of its employees from any and all liability for
damages our child may suffer as a result of this request.

Thank you for your Cooperation.

Date

Signature of Parent/Guardian

School Nurse