Randolph County Schools

**PARENT REQUEST FOR ADMINISTRATION OF MEDICATIONS**

**DURING 5TH GRADE OUTDOOR EDUCATION PROGRAM**

**LIST ONLY ONE MEDICATION PER REQUEST**

Name of Student _____ D.O.B. _____ School _____ Grade _____

Home Room Teacher _____ Family Doctor _____ Doctor's Phone No. _____

I request that the following medication be administered to my child named above.

Name of medication _____ Route or Method of Administration _____
Oral, topical, etc.

Dose _____ (Give oral dose in mg, not in number of pills to take.)

*Dose of any over-the-counter medication may not exceed the manufacturer's recommendations as age appropriate.*

Time(s) it is to be given _____ Frequency it may be given if PRN (only as needed) _____

What is this medication being given for? What is the intended effect? _____

List only other daily medication taken by the student _____

List any student allergies _____

_____ _____ _____ _____

Parent/Guardian Signature | Date | Daytime Telephone Number | Alternate or Emergency Telephone Number

**MEDICATION ADMINISTRATION RECORD**

| DATE | TIME | * | COMMENTS | DATE | TIME | * | COMMENTS |
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* = INITIALS OF PERSON ADMINISTERING MEDICATION _____ FULL NAME _____

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