PENTA CAREER CENTER
9301 Buck Road • Perrysburg, OH 43551 • P. 419-666-1120 • F. 419-661-6634

Request to Administer Medication

Student Name: _____ Date of Birth: _____

Address: _____
Street City Zip

Grade: _____ Career Program: _____ Member School: _____

Name of Drug: _____

Dosage: _____ Administration Time: _____

Date to Begin: _____ through _____ or End of School Year (circle)

Possible adverse reactions which should be reported to physician: _____

_____

Special Instructions: _____

_____

Name of Drug: _____

Dosage: _____ Administration Time: _____

Date to Begin: _____ through _____ or End of School Year (circle)

Possible adverse reactions which should be reported to physician: _____

_____

Special Instructions: _____

_____

Authorization to Self-Carry/Administer: _____/_____ Asthma Inhaler _____/_____ Epinephrine Pen
Initials parent/guardian/ physician parent/guardian/ physician

_____ _____ _____ _____
**Parent/Guardian Signature Date **Physician Signature Date

Physician Name (printed): _____

Address: _____ Phone: _____
Street City Zip

NOTE: The parent/guardian must agree to (1) deliver the medication to school (2) Notify the school if a change in prescription is made along with the physician's written statement of changes (3) Notify the school if the medication, the dose, or the procedure is changed or discontinued (4) Pick up any medication which is considered a controlled substance (ADHD medications/narcotics) when it is discontinued or at the end of the school year.

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