

**DOWNEY UNIFIED SCHOOL DISTRICT**  
**PARENT REQUEST FOR MEDICATION ADMINISTRATION**

(To be used for medication that is given for two (2) weeks or less)

STUDENT NAME \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

\*\*\*\*\*

NAME OF MEDICATION \_\_\_\_\_

PRESCRIPTION NUMBER \_\_\_\_\_

MEDICATION EXPIRATION DATE \_\_\_\_\_

DOSE OF MEDICATION \_\_\_\_\_

TIME TO BE GIVEN \_\_\_\_\_

METHOD OF ADMINISTRATION \_\_\_\_\_

NUMBER OF DAYS TO BE GIVEN \_\_\_\_\_

LAST DATE OF MEDICATION ADMINISTRATION \_\_\_\_\_

\*\*\*\*\*

As the parent of the above named student, I give the school permission to administer this medication to my child during school hours as described above.

Parent Signature \_\_\_\_\_

Date \_\_\_\_\_

\*\*\*\*\*

**FOR OFFICE USE ONLY**

**LOG OF MEDICATION ADMINISTRATION**

No.	Date	Time	Signature	No.	Date	Time	Signature
1				6			
2				7			
3				8			
4				9			
5				10			

**DISTRITO ESCOLAR UNIFICADO DE DOWNEY**

**PETICION DE PADRES PARA ADMINISTRAR MEDICAMENTOS**

**(Se debe usar para medicamentos que se deben de administrar por (2) semanas o menos)**

NOMBRE DEL ESTUDIANTE \_\_\_\_\_ Fecha de Nacimiento \_\_\_\_\_ Grado \_\_\_\_\_

\*\*\*\*\*

NOMBRE DEL MEDICAMENTO \_\_\_\_\_

NUMERO DE LA PRESCRIPCION \_\_\_\_\_

DOSIS DE MEDICINA \_\_\_\_\_

HORA QUE SE DEBE DAR \_\_\_\_\_

METODO DE ADMINISTRACION \_\_\_\_\_

NUMERO DE DIAS QUE SE DEBE DAR LA MEDICINA \_\_\_\_\_

\*\*\*\*\*

Como el padre o madre de el/la alumno/a mencionado arriba, doy permiso al personal escolar para administrar el medicamento a mi hijo/a durante horas de escuela como lo he se ñalado arriba.

Firma del Padre o Madre o Guardián \_\_\_\_\_

Fecha \_\_\_\_\_

\*\*\*\*\*

**FOR OFFICE USE ONLY**

**LOG OF MEDICATION ADMINISTRATION**

No.	Date	Time	Signature	No.	Date	Time	Signature
1				6			
2				7			
3				8			
4				9			
5				10			