STUDENT MEDICATION REQUEST FORM

(For Prescription and Non-prescription Medications)

School: _____ Student's Name: _____

School Year:_____ Class/Teacher _____ Date of Birth _____

To be Completed By Prescribing Physician

_____ of _____ is under my care and
(Student's Name) (Address)

should receive _____ at the
(Name of Drug) (Dosage) (Route)

following time(s) _____

Date administration of drug is to begin: _____
Date administration of drug is to end: _____
Severe adverse reactions which should be reported to the doctor: _____
Special Instructions for administering the drug: _____
Storage requirements or sterile conditions needed for the drug: _____

Should a change in any of the above information occur,
a revised written physician's statement must be submitted to the school.

_____ _____
Physician's Printed Name Date

_____ _____
Physician's Signature Physician's Phone Number

To be Completed By Parent or Guardian

I hereby request and give my permission to the principal or his designed (e.g. School nurse or other responsible Board authorized person) to administer the above medication to my child as instructed by the physician.

All medication must be brought to the school in the original container as dispensed by the pharmacist or physician, clearly labeled. Ask the pharmacist to give you two containers. Send only the amount of medication that will be administered during school hours. Medications will be kept in the clinic/office.

If any revisions in the above plan or doctor's statement occur, a written revised doctor's statement must be submitted to the school. (It is understood that it is the student's responsibility to seek the mediation at the proper location and time unless he/she is physically or mentally unable to do so).

Parent/Guardian's Signature:_____ Date:_____ Phone: _____

SCHOOL USE: Date Received_____ Initialed by _____