Request for Medication to be taken during school hours
This form must be renewed each school year

To be completed by parent: (for all medications)

Name of student: _____ Grade: _____

_____	_____	_____	_____
name of medication	Dose	time(s) to be given	number of days

I request that my child, named above, be assisted in taking the prescribed medication at school by authorized persons. I agree to comply with the school's policies and procedures. I have provided the medication in its original container and labeled as above.

_____	_____	_____
Date	Daytime telephone number	Parent/Guardian signature

To be completed by a licensed physician: for all medications, including over the Counter

_____	_____
Name of medication	Purpose of medication

_____	_____	_____	_____
Date Prescribed	Dosage	Frequency	Duration

Precautions, special instructions, possible side effects, comments:

_____

_____

_____

The student named above , for whom this medication is prescribed, is under my care.

_____	_____
Print name of physician	Signature of Physician
_____	_____
Date	Telephone number

Please Log Medication Administration on Reverse Side