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)

Student Name: _____ Grade: _____

Name of medication	Dosage	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 it is labeled as stated 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, and or 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 ***