REQUEST FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS

(To be completed by a licensed physician)

☐ **PRESCRIPTION** ☐ **OVER-THE-COUNTER**

Student name_____ _____
Last First Sex

_____ _____
Date of Birth School

Name of medication_____ Date of prescription_____

Dosage Prescribed_____ Dose form_____
(Tablet, liquid, inhalant, etc.)

Time schedule at school_____

Length of time this medication will be necessary_____

Purpose of medication or diagnosis_____

Physician's Recommendations (if any)_____

- The student for whom this medication is prescribed is under my care.

_____ _____ _____
Print name of Licensed Physician Signature of Licensed Physician Date

_____ _____
Address City State Zip code Telephone

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(To be completed by parent/guardian)

I request that my child, _____, be assisted in using prescribed medication at school. I assume full responsibility for supplying all medication and shall deliver it to the school and agree to the policies and procedures listed on the reverse side.

_____ _____ _____ _____
Date Signature of Parent/Guardian Home Phone Emergency Phone