

Name of School
 Address
 Phone/Fax

**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 or over-the-counter medication at school by authorized persons and will 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/Legal Guardian Signature _____

TO BE COMPLETED BY A LICENSED PHYSICIAN: (for all prescriptions and aspirin)

Name of Medication _____ Purpose of Medication _____

Dosage Prescribed _____ Time Scheduled _____ Dose Form(tablet, liquid, etc) _____

Date of Prescription _____ Length of Time This Medication Will Be Necessary _____

PRECAUTIONS, SPECIAL INSTRUCTIONS, POSSIBLE ADVERSE EFFECTS, COMMENTS:

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

Print Name of Physician _____ Signature of Physician _____

Telephone Number _____ Date _____