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 PHYSICAN: (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