

REQUEST FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS

(To be completed by a licensed clinician)

Last Name of Student _____ First Name _____

Sex _____ Birthdate _____ School Name _____

Purpose of Medication or Diagnosis _____

Name of Medication _____

Dosage Prescribed _____ Time Schedule _____ Dose Form _____ Color _____

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

Clinician's Recommendations (Check where applicable):

- Please notify this office if my patient misses medication at school.
- Student may self-carry/self-administer medication
- Medication may have adverse effects (explain)
- Special instructions and/or comments

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

Print Name of Licensed Clinician _____

Signature of Licensed Clinician _____

Address _____ Telephone _____ Date _____

(Do Not Detach)

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(To be completed by parent/guardian)

I request that my child, _____, be assisted/supervised in taking the above prescribed medication at school. I will comply with the policies and procedures determined by the School District.

Date _____ Home Telephone _____ Emergency Telephone _____

Signature of Parent/Guardian/Student 18 years or older