

**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 \_\_\_\_\_

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(Do Not Detach)

**REQUEST FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS**

(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