STUDENT MEDICATION REQUEST FORM
For Prescription and Nonprescription Medications

Student's Name_____ School _____

Student's Date of Birth _____ School Year _____

TO BE COMPLETED BY PRESCRIBING PHYSICIAN

_____ is under my care and should receive the following medication(s):
(Name of Student)

Name of Drug	**Dosage and Time**	**Date to begin Medication**	**Date to end Medication**	**Special Instructions**	**Storage/Sterile requirements**

Should a change in any of the above information occur, a revised written physician's statement must be submitted to the school.

_____ _____ _____ _____
Physician's Printed Name Physician's Phone # Physician's Signature Date

TO BE COMPLETED BY PARENT/GUARDIAN

I hereby request and give my permission to the Principal or designee to administer the above medication to my child as instructed by the Physician.

All medication must be brought to the school in the original container as dispensed by the Pharmacist or Physician, clearly labeled. Ask the Pharmacist to give you two containers. Send only the amount of medication that will be administered during school hours. Medications will be kept in the clinic/office.

If any revisions in the above plan or Doctor's statement occur, a written revised Doctor's statement must be submitted to the school. It is understood that it is the student's responsibility to seek the medication at the proper location and time unless he/she is physically or mentally unable to do so.

_____ _____ _____ _____
Parent's Printed Name Parent's Phone # Parent's Signature Date

School Use: Date Received _____ Received by_____