MEDICATION REQUEST FORM

NAME OF STUDENT:_____**DOB**:_____
(On pharmacy label or handwritten on non-prescription container)

Only those medications that are medically necessary during school hours for a student's attendance or written in an IEP should be sent to school. School personnel are not responsible for any ill effects that might occur from this medication.

Persons who may assist your child with medications include the school nurse (RN) and trained campus staff. Parent/guardian must give a written request. The medication must be in the original container and properly labeled with the student's first and last name. This a state requirement.

NOTE: If the medication is a prescription, ask your pharmacist to prepare two labeled containers, one for school and one for home. **THE VERY FIRST DOSE OF THIS MEDICATION FOR CURRENT CONDITION/ILLNESS <u>MAY NOT BE GIVEN AT SCHOOL.</u>**

NAME OF MEDICATION: _____PHYSICIAN:_____

DOSAGE (amount):_____

TIME TO BE GIVEN AT SCHOOL:_____

REASON STUDENT IS TAKING MEDICATION:_____

DATES TO BE GIVEN FROM:_____TO:_____

HOW IT IS TAKEN:_____
(Example: by mouth, by inhaler, with food or after meals)

WHEN WAS FIRST DOSE OF THIS MEDICATION GIVEN? _____

_____ **_____**
PARENT/GUARDIAN SIGNATURE **DAYTIME PHONE**

_____
DATE

Date Reviewed by RN:_____ Staff_____may/_____may not administer

_____
RN Signature