Request for Dispensing Medication During School Hours

Please complete the following information if medication (prescription or non-prescription) is to be administered during school hours.

Name of Student:_________________________________School:________________________

Date of Birth:______________________Grade:_________________________

-To Be Completed By Your Child's Physician-

Diagnosis for which medication is necessary:____

Name of Medication:____

Dosage:____

Time to be administered:____

If medication is to be administered PRN, please list under what conditions it should be given and how often it may be repeated.____

Length of time student will require medication:_______________________________________

Are there any restrictions?____________If yes, what and for how long? ___________________

____

Is it necessary that this medication be given during school hours?_________________________

Physician's Signature:_______________________________________Date:________________

Print name of Physician:_____________________________________Phone #:______________

-To Be Completed By Parent/Guardian-

I give permission for my child to receive the above medication during school hours as directed on this form by my child's physician.

Signature of Parent: ____Date:_____________

Home/Cell #: ___________________________________Work #:_________________________