

REQUEST FOR GIVING MEDICINE AT SCHOOL

PUPIL'S NAME _____ GRADE _____

TEACHER'S NAME _____

MEDICATION _____ Dosage _____

ILLNESS/CONDITION REQUIRING MEDICATION _____

PRESCRIBING PHYSICIAN _____

TIME TO BE GIVEN _____ A.M. _____ P.M.

DATE FROM _____ TO _____

1. Prescription medications must be in the original prescription bottle. You can ask your pharmacist for a labeled school bottle. All prescription medications must be accompanied by this form with parent/guardian signature.
2. Over-the-counter medications must be in the original container marked with the student name. All over-the-counter medications must be accompanied by this form with parent/guardian signature.

The purpose of this policy is to establish and maintain a system of safe storage, handling, and dispensing prescribed medicine at school.

Parent or Guardian

Date