

**REQUEST FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS  
THIS FORM MUST BE RENEWED EACH SCHOOL YEAR**

**TO BE COMPLETED BY PARENT: (for all medications)**

Name of Student \_\_\_\_\_ Grade \_\_\_\_\_

Name of Medication _____	Dose _____	Time(s) to be given _____	Number of Days _____
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I request that my child, named above, be assisted in taking the prescribed or over-the-counter medication at school by authorized persons and will comply with the school's policies and procedures. I have provided the medication in its original container and labeled as above.

Date _____	Daytime Telephone Number _____	Parent/Legal Guardian Signature _____
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**TO BE COMPLETED BY A LICENSED PHYSICIAN: (for all prescriptions and aspirin)**

Name of Medication _____	Purpose of Medication _____
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Dosage Prescribed _____	Time Scheduled _____	Dose Form(tablet, liquid, etc) _____
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Date of Prescription _____	Length of Time This Medication Will Be Necessary _____
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**PRECAUTIONS, SPECIAL INSTRUCTIONS, POSSIBLE ADVERSE EFFECTS, COMMENTS:**

The student named above, for whom this medication is prescribed, is under my care.

Print Name of Physician _____	Signature of Physician _____
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Telephone Number _____	Date _____
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