

Medication Request Form

Students Name _____ Grade _____ Birthdate _____

Parent's Name _____

Parent's Address _____

Phone Numbers: Home _____ Work _____ Cell _____

Doctor's Name _____ Phone Number _____

I request that the School Nurse, or other delegated school personnel, administer the following medication to the above named student.

Name of medication(s) _____

Has your child received at least one dose of this medication? Yes _____ No _____

Reason for medication(s) _____

What time should medication be given at school? _____

How much medication should be given? _____

If appropriate, can this medication be repeated? No ___ Yes ___ If yes, how soon? _____

How is this med to be given? Circle one: By mouth, inhaled, nose, eyes, ears, rectally, injection.

How long will the student be taking the medication? _____

Should short-term medication (cough medicine, antibiotics, inhalers, etc.) be sent home daily?

Yes _____ No _____

I have reviewed the U.S.D. #489 Medication Request Procedure and agree to the stipulations attached. Please note that medical and health related information may be shared with appropriate school personnel.

Signature of Parent or Guardian _____

Date _____

Students requiring daily medications will be responsible for reporting to the Health Office at the specified time.

12-07