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 Ofstudent: _____ Grade: _____

_____ _____ _____ _____

name ofmedication Dose time(s) to be given number Of days

I request that my child, named above, be assisted in taking the prescribed medication at school by authorized persons. I agree to 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 ParentlGuardian signature

To be completed by licensed physician: for all medications, including over the Counter

_____ _____

Name of medication Purpose of medication

_____ _____ _____ _____

Date Prescribed Dosage Frequency Duration Precautions, special instructions,

possible side effects, comments:

_____

_____

_____

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

_____ _____

Print name of physician Signature of Physician

_____ _____

Date Telephone number

Please Log

Medication Administration on Reverse Side

05/10/00

Medication Administration Log

Grade: _____ Year: _____

Student: _____ / Initials: ___ Medication: _____ Dosage: _____ Time(s) to be given: _____

Directions: For each day a medication is administered enter your initials in the date box corresponding with the correct month.
Use the key to document reasons the medication was not given.
If more than two doses are given on the same day, draw a diagonal line through the square and initial each area as given.
Draw a line or x through the unused dates.
Maintain this form for three years after the student will turn 21.

Key: A: absent, X: school not in session, D/C: discontinued, N/A: Not available, R: refused, M: missed

month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Aug																															
Sept																															
Oct																															
Nov																															
Dec																															
Jan																															
Feb																															
March																															
April																															
May																															
June																															

Persons Administering Medications

Printed Name	Signature	Initials	Title	Date