

REQUEST FOR GIVING MEDICINE AT SCHOOL

Name of Student _____

Teacher _____

Medication _____

Time to be given _____ A.M. Time to be given _____ P.M.

Date from _____ to _____

This medicine is to be furnished by parent or guardian with the regular label from the pharmacist, plus the name and strength of the medicine. This request must be signed by the parent or gaurdian and may be signed by the physician/pharmacist to authorize giving medication during school hours.

Parent's or Legal Guardian's Signature

Date

Physician's Signature (Optional)

Date