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**