

MEDICATION REQUEST FORM

PARENT/GUARDIAN AUTHORIZATION SECTION (Required for ALL Medications Administered At School)

Student's Name _____ Date of Birth _____ Grade _____

Parent/Guardian Name _____ Phone _____

Medication Name _____

Reason for medication _____

Form of medication (check one): _____ tablet/capsule _____ liquid _____ other (_____)

Instructions: *Dosage* _____ *Time to be given* _____

Start date: _____ Stop date: _____ End of School Year _____ other (_____)

This medication is: long term short term as needed

I hereby release the Shawano School District Board of Education and its agents and employees from any and all liability that may result from my child taking the medication identified on this form. I give permission for the School Nurse to contact the physician named herein if any questions arise regarding the administration of this medication.

Parent/Guardian Signature _____ Date _____

PHYSICIAN'S INSTRUCTIONS: (Required for ALL Prescription Medications Administered at School)

I am prescribing medication for (patient's name) _____

Name of medication _____

Reason for medication _____

Form of medication: _____ tablet/capsule _____ liquid _____ other (_____)

Instructions: *Dosage* _____ *Time(s) to be given* _____

Start Date: _____ Stop Date: _____ School Year _____ other (_____)

This medication is: long term short term as needed

I will provide additional instructions to the school if this medication is discontinued, or if the dosage or time of administration is changed. I will accept communication from the School Nurse if questions arise regarding the administration of this medication.

Physician Name (print) _____ Telephone _____

Physician Signature _____ Date _____