MEDICATION REQUEST FORM

Please note: This form must be completed and signed by the parent **and** the student's Licensed Healthcare Provider (LHP)-with prescriptive authority. This form is for both **prescription** and **nonprescription** medication. Complete a separate form for **each** medication. All medication must be transported to and from the school by a responsible adult.

PARENT REQUEST

STUDENT NAME ________________________________ SCHOOL ______________________________

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student and request and authorize the school to dispense medication to the above identified student in accordance with the prescription or LHP's instructions for the period commencing: START DATE ___________ TERMINATION DATE___________ or END of SCHOOL YEAR-including summer school activities Yes_____ No_____

In the event of half-day school schedule, I want my child to take his/her medication at school: _____ Yes _____ No

______________________ ____

Date Parent Signature

_________________________ __________________________

Home Phone Work Phone

LICENSED HEALTHCARE PROVIDER REQUEST

MEDICATION (Name, Dosage) ____

ADMINISTRATION SCHEDULE ____

REASON FOR MEDICATION ____

FURTHER INSTRUCTIONS (possible reactions, etc.): This section must be completed if medication is to be dispensed *for more than 15 days*. ____

____

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated above for the period commencing: START DATE__________TERMINATION DATE: _____________ or END of SCHOOL YEAR-including summer school activities Yes_____ No_____ , as there exists a valid health reason which makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials.

________________________ ____

Date Licensed Healthcare Provider Signature

________________________ ____

Office Phone Name (Please print)

(2-03)

MEDICATION RECORD

This record must be retained for eight (8) years.

MEDICATION ADMINISTRATION RECORD

This record must be retained for eight (8) years

STUDENT NAME ____ BIRTHDATE _________________ GRADE _____________

NAME OF MEDICATION __________________________________ DOSAGE ____________ ________ TIME _______________

DATE	TIME	PILLS LEFT	INITIALS	COMMENTS	DATE	TIME	PILLS LEFT	INITIALS	COMMENTS

INITIALS _________ SIGNATURE ________________________ INITIALS __________ SIGNATURE __________________________

INITIALS _________ SIGNATURE ________________________ INITIALS __________ SIGNATURE __________________________