File: JHCD-E

Norwayne Local School District

STUDENT MEDICATION REQUEST FORM

(For Prescription and Nonprescription Medications)

School _____ Student's Name _____

School Year _____

Class/Teacher _____ Date of Birth _____

(*To be completed by Prescribing Physician*)

_____ of _____ is under my care and

(Name of Student) (Address)

should receive _____

(name of drug) (dosage) (route)

at the following time(s) _____

Date administration of drug is to begin _____

Date administration of drug is to end _____

Severe, adverse reactions which should be reported to the doctor: _____

_____

Special instructions for administering the drug: _____

_____

Storage requirements or sterile conditions needed for the drug: _____

_____

Should a change in any of the above information occur, a revised physician's statement must be submitted to the school.

_____
(PHYSICIAN'S PRINTED NAME)

_____
(PHYSICIAN'S SIGNATURE)

Date _____

(To be completed by Parent or Guardian)

I hereby request and give my permission to the principal or his/her designee (e.g., school nurse or responsible Board authorized person) to administer the above medication to my child as instructed by the physician.

ALL medication must be brought to the school in the original container as dispensed by the pharmacist or physician, clearly labeled. Ask the pharmacist to give you two containers. Send only the amount of medication that will be administered during school hours. Medications will be kept in the office.

If any revisions in the above plan or doctor's statement occur, a written revised doctor's statement must be submitted to the school. **It is understood that it is the student's responsibility to seek the medication at the proper location and time unless he/she is physically or mentally unable to do to.**

PARENT'S OR GUARDIAN'S SIGNATURE _____

Date _____ Parent/Guardian telephone number _____

School Use: Date Received _____ Initialed by _____