Medication Request Form

Student's Full Name: _____

Grade: _____ Teacher/Homeroom Class: _____

Over-the-counter Medication

I request that the school personnel administer (any or none) of the following medications to my child as needed. No medications may be given without a **SIGNED** permission form from a parent/guardian and a physician for each new school year. *Also, please be advised that any of the above medications used by your child on a chronic basis should be supplied from home (i.e. cough drops).* **Students are not permitted to have any type of medication with them at any time- with the exception of ASTHMA medication.**

	Yes	No
Tylenol (Acetaminophen) *Specify dosage*		
Advil (Ibuprofen) *Specify dosage*		
Tums		
Saline Eye Drops		
Cough Drops		
Antibotic Ointment		
Cortisone Cream		
Benadryl Allergy Medication		
Calamine Lotion		
Vitamins, food supplements, and/or modified diet		
Other		

_____

Parent/Guardian Signature Date

_____

Physician Signature Date

Please list any vitamins, supplements, and/or dietary requirements to be received while at school.

_____

_____

Prescription Medication

Any specific medication prescribed by your physician requires a physician's signature. This medication **MUST** be in the original container, currently dated, labeled with the name of the medication, the dosage, and times to be given. The physician's name must also be on the label if it is a prescribed medication.

Name of drug: _____ Today's Date: _____

Dosage: _____ Route: _____

Specific instructions for school nurse/administrator: _____

Possible side effects to watch for: _____

Expiration date for this request: _____

_____

Physician's Signature Date

_____

Physician's Phone Number