DIVISION OF INSTRUCTION
DEPARTMENT OF PUPIL PERSONNEL SERVICES
HEALTH SERVICES

REQUEST FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS

TO BE COMPLETED BY PARENT:

LAST NAME OF PUPIL | FIRST NAME | SEX | DATE OF BIRTH | SCHOOL

I request that my child, named above, be assisted in taking the prescribed medication at school by authorized persons, and will comply with the school's policies and procedures.

DATE | TELEPHONE | SIGNATURE, PARENT OR GUARDIAN

TO BE COMPLETED BY A LICENSED PHYSICIAN:

PURPOSE OF MEDICATION | NAME OF MEDICATION

DOSAGE PRESCRIBED | TIME SCHEDULE | DOSE FORM (TABLET, LIQUID, ETC.)

DATE OF PRESCRIPTION | LENGTH OF TIME THIS MEDICATION WILL BE NECESSARY

Precautions, Special Instructions, Possible Adverse Effects, Comments:

The pupil named above, for whom this medication is prescribed, is under my care.

PRINT NAME OF PHYSICIAN | SIGNATURE OF PHYSICIAN

ADDRESS | TELEPHONE | DATE

MUST BE RENEWED EACH SCHOOL YEAR

PPSD-5
REVISED 9-75