



PARENT REQUEST FOR DISPENSING MEDICATION AT SCHOOL

I request school personnel to dispense medication to my child, _____

Start Date _____ End Date _____

Times _____

The name of the medication is _____

****Prescribed medications must be in a pharmacy bottle with the physician's name on the label and accompanied by a doctor's note or copy of the script.***

Exact Dosage _____

Date Prescription Filled _____ Expiration Date _____

My child's physician's name is _____

Physician's Address _____

Physician's Phone number _____

Signature of Parent/Guardian _____

Phone Number: _____

Staff Use Only

<u>Day</u>	<u>Time</u>	<u>Dosage</u>	<u>Signature of Person Administering</u>