Physician's Request for Giving Medication at School Must be Updated Each Academic Year

(To be completed by the prescribing physician)

I request that _____receive the following medication at school as directed.

Please print clearly

Name of Medication	Dosage	Time to be administered	Anticipated period ofuse

Physician's Signature _____ Date _____

Name (print or use stamp) _____

Address _____

Phone # _____ Fax # _____

* **Note to parents concerning medications to be administered at school:**

DO NOT send prescription medication in the original bottle or package. You must provide a pill container, clearly labeled with the child's name and the days of the week. The appropriate dosage must be placed in the proper daily section.