THIS FORM REQUIRES A MEDICAL DOCTOR'S SIGNATURE



REQUEST FOR ASSISTANCE WITH MEDICATION DURING REGULAR SCHOOL DAY

School districts require that all students who need medication during school hours must do the following:

- 1. Present a written statement from the student's physician detailing the method, amount, and time schedules for taking of the medication.
- 2. Present a written statement from the student's parent/guardian requesting the District to assist the student with the proper procedure of taking the medication.
- 3. The medication must be in the <u>original bottle or package</u>, and properly labeled.
- **Students may not carry medications on their persons or keep it in their lockers.

Parent/Guardian Request for Assistance:			
Student Name	Sex	Date of Birth	
I request that the designated District personnedication in accordance with the instruction communicate with the physician below regulauthorized the physician to communicate wadministration. I authorize the designated Estaff as needed.	ctions provided below by the physician arding my child's medical condition and with the District for any special circumsta	. I authorized the District to /or the medication prescribed ances related to the medication	
Parent Signature	Phone	Date	
Licensed Physician's Medication Instruction	<u>ns</u>		
Name of Medication	Purpos	Purpose	
Date of Prescription	Length of time to be taken		
Instructions for administrating the medication	on		
Describe precautions, special instructions, si	ide effects or other (please include stora	ge instructions)	
I am the prescribing physician for the above	e student:		
Printed Name of Physician			
Address	Telephone	Date	
Signature and License Number of Physician			