REQUEST FOR SCHOOL TO ADMINISTER RX OR NON-RX MEDICATION

Child's name: ____

Date of Birth: __________________ **Sex:** ___________________________ **Weight** __________

Name of Medication: ____________________________ **Dosage:** ________________________

____ ________________________

____ ________________________

Schedule of medication to be administered at School:

_____________ **tablet(s) by mouth at** ____________

_____________ **tablet(s) by mouth at** ____________

_____________ **tablet(s) by mouth at** ____________

Reason for medication: ____

Duration of treatment:_______________________ **Side effects:** _________________________

If you have any questions please call:

____ ________________________________

NAME (please print) **PHONE NUMBER**

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SIGNATURE