

## REQUEST FOR GIVING MEDICATION AT SCHOOL

The medicine is to be furnished by the parent and is to be labeled with the name of the medicine, the amount to be given, time of day to be given and the expected duration of treatment.

### FOR NON-PRESCRIPTION MEDICATION:

I request that the designated school staff see that my child \_\_\_\_\_  
Child's Name

receives the medication \_\_\_\_\_ for the period from  
\_\_\_\_\_ to \_\_\_\_\_.

I agree to notify the school in writing at the termination of this request or when any change in medication occurs.

**SIGNATURE OF PARENT/GUARDIAN** \_\_\_\_\_ **DATE** \_\_\_\_\_

### FOR PRESCRIPTION MEDICATION:

I request that the designated school staff see that my child \_\_\_\_\_  
Child's Name

receives the medication \_\_\_\_\_ for the period from  
\_\_\_\_\_ to \_\_\_\_\_.

I agree to notify the school in writing at the termination of this request or when any change in medication occurs.

**SIGNATURE OF PARENT/GUARDIAN** \_\_\_\_\_ **DATE** \_\_\_\_\_

**TO THE PHYSICIAN:** According to the State of Wisconsin Medical Examining Board and the School District, the following information must be completed in order for the school personnel to dispense or administer medications.

**Name of Medicine** \_\_\_\_\_

**Amount to be given** \_\_\_\_\_

**Duration of treatment** \_\_\_\_\_

Side effects that school staff should be aware of: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I should be contacted regarding the following conditions of reactions of the above student who is receiving the medication(s) noted above: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I am willing to accept direct communication from the person dispensing or administering the medication.

**PHYSICIAN'S SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**PRINCIPAL'S SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_