MEDICATION REQUEST FORM

PARENT/GUARDIAN AUTHORIZATION SECTION **(Required for ALL Medications Administered At School)**

Student's Name____ **Date of Birth**__________________ **Grade**__________________

Parent/Guardian Name ____ **Phone** _______________________

Medication Name ____

Reason for medication ____

Form of medication (check one): _______**tablet/capsule** _______ **liquid** ________ **other (** ___________________**)**

Instructions: Dosage ________________________________ **Time to be given** _______________________________________

Start date: _____________ **Stop date:** ______________ **End of School Year** ________ **other (**___________**)**

This medication is ☐ **long term** ☐ **short term** ☐ **as needed**

I hereby release the Shawano School District Board of Education and its agents and employees from any and all liability that may result from my child taking the medication identified on this form. I give permission for the School Nurse to contact the physician named herein if any questions arise regarding the administration of this medication.

Parent/Guardian Signature ____ **Date:** _______________________

PHYSICIAN'S INSTRUCTIONS: **(Required for All Prescription Medications Administered at School)**

I am prescribing medication for (patient's name) ____

Name of medication ____

Reason for medication ____

Form of medication: _______ **tablet/capsule** _______ **liquid** _______**other (**_________________________**)**

Instructions: Dosage ______________________________ **Time(s) to be given** ____________________________

Start Date: _________________ **Stop Date:** _____________ **School Year** ___________________ **Other (**_______________________**)**

This medication is ☐ **long term** ☐ **short term** ☐ **as needed**

I will provide additional instructions to the school if this medication is discontinued, or if the dosage or time of administration is changed. I will accept communication from the School Nurse if questions arise regarding the administration of this medication.

Physician Name (print) ____ **Telephone** _______________________

Physician Signature ____ **Date** ___________________________