

NINE MILE FALLS SCHOOL DISTRICT
MEDICATION REQUEST FORM

*This form must be completed and signed by the Physician/ Licensed Health Care Provider
and Parent for both prescription and nonprescription medication.*

Student Name: _____ Birth Date: _____

School: _____ Grade: _____ Teacher: _____

**THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH PROFESSIONAL
PRESCRIBING WITHIN THE SCOPE OF THEIR PRESCRIPTIVE AUTHORITY**

Medication (Name, Dosage): _____

Administration Schedule: _____

Reason for Medication: _____

If given "as needed" (PRN), specify the length of time between doses: _____

For inhalers, indicate if student can carry and self-administer: _____

Student has permission to carry and self-administer own medication, including over-the-counter medications: Yes No

If samples of medication are given, they must be labeled with student's name, dosage, and time to be given.

I request and authorize that the above named student be administered the above identified oral medication in accordance with the instructions indicated above for the period _____ (date) to _____ (date) as there exists a valid health reason which makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials.

Instructions for medication dispensed for more than 15 days: _____

Signature of Licensed Health Professional

Date

Name (Print or Type)

Telephone Number

THIS PORTION TO BE COMPLETED BY THE PARENT/ GUARDIAN

I request and authorize that the above named student be administered the above identified oral medication in accordance with the instructions indicated above for the period _____ (date) to _____ (date), as there exists a valid health reason which makes administration of the medication advisable during school hours. I understand and agree that because of schedules and other responsibilities, a dosage or dosages may be delayed or missed. I understand the school will work diligently to see that medication is given in timely manner, but that on occasion, due to changes in student's schedules, absences or unforeseen complications a dose may be missed, if so you will be notified.

Permission to carry and self-administer inhaler Yes No

Permission to carry own medication Yes No

Permission to self-administer Medication Yes No

Parent / Guardian Signature

Date of Signature

Telephone: work / home

Student Signature, when carrying and self-administering medication
Med Req 4/03

