South O'Brien Community School District

REQUEST FOR GIVING MEDICATION AT SCHOOL

(Complete one sheet for each medication)

Student's Name _____

Medication _____ Dose _____

Time to be given at school _____AM _____PM

Date From _____ To _____

This medication is furnished by parent or guardian with the regular label from the pharmacist, plus the name and strength of the medicine. This request must be signed by parent or guardian to authorize giving the medication during school hours.

_____

Parent/Guardian Signature **Date**

Significant Information _____

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