



REQUEST TO DISPENSE PRESCRIPTION MEDICATION

SCHOOL YEAR: _____

Family Last Name: _____

(Please Print Legibly)

To Be Completed by the Physician:

Since medication for the student listed below cannot be scheduled for other than school hours and the administration of such medication may be supervised by non-medical personnel, it is requested that the medication as indicated below be administered by the Head of School's designee.

Name of Student: _____

Birthday of Student: _____

Medication	Dosage	Prescription Start Date	Prescription End Date	Purpose

Possible reaction that, if they occur, should be reported to the physician: _____

Any special instructions (e.g., storage): _____

Physician's Signature: _____

Date: _____

Physician's Phone Number: _____

Emergency Number: _____

To Be Completed by the Parent / Guardian:

- I request the medication to be administered to our child in accordance with the instructions of our physician, Dr. _____
- I understand that the administration of the medication listed above is to be dispensed under the supervision of the Head of School's designee.
- I understand that the medication is to be delivered to the school by the parent/guardian and unused medication will be returned to the parent/guardian only. Medication not collected within the date of notification will be disposed of by the Head of School's designee.
- I agree to deliver a month's supply of medication (for ongoing prescriptions) in the original container the first school day of each month unless other arrangements are made with the Head of School's designee. I understand the empty container will be returned home the last school day of each month with the student.
- I agree to notify the school immediately if:
 - We change physicians.
 - The medication or dose is changed.
 - The administration of the medication is to be terminated.

Signature / Date: _____

Daytime Phone: _____

Authorized Person Receiving Medication: _____

Date/Time: _____