PARENT'S REQUEST FOR GIVING MEDICATION AT SCHOOL

I have completely read and understand the Jackson R-2 District's Medication Administration Guidelines and am requesting the nurse and assistive personnel to give the medication listed below. It is my responsibility to notify the school nurse of any changes in my child's medication during the school year.

Student: _____ Grade: _____ School: _____

Name of Prescribed Medication: _____

For treatment of: _____

Exact Dosage: _____ Time to be Given: _____

Date to Begin: _____ Date to End: _____ Number of pills delivered: _____

Name of Pharmacy: _____ Phone: _____

Name of Physician: _____ Phone: _____

Who will pick up unused medication: _____

Parent/Guardian Signature: _____ Date: _____

Phone: _____

Medication Updates:

Date:_____ Changes: _____

_____

Parent Signature: _____ Nurse Signature: _____

Date: _____ Changes: _____

_____

Parent Signature: _____ Nurse Signature: _____

Date: _____ Changes: _____

_____

Parent Signature: _____ Nurse Signature: _____

9/20 sc

Date	Medication Received/Returned	Initials