PUPIL MEDICATION REQUEST

NAME OF CHILD________________________________ CLASS_________

HOME ADDRESS____

____

NAME & PURPOSE OF MEDICATION_______________________________

____

DOSAGE AND METHOD OF ADMINISTRATION_____________________

____

FREQUENCY OF ADMINISTRATION________________________________

POSSIBLE SIDE EFFECTS____

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I understand that it is my child's responsibility to come to the office for their medication

PARENTS HOME TEL. NO ____________________________________

WORK/MOBILE NO____

SIGNED________________________________ DATE___________________

We will not administer any prescribed medication unless it is in original packaging, with dispensing label