MEDICATION TO BE GIVEN AT SCHOOL :SIGNED APPROVAL

Student_____ Age_____ D.O.B._____
Last Name First Middle

School_____ Grade_____

Name and Dose of Medication	Form: (tab,cap, pill, other) :	Number to be taken	Approximate time or day

Parents

Do you wish for this child to receive medication at school? Yes_____ No_____
Please bring medication to the school (Do not send with student).
The law allows any person (not necessarily a nurse) to assist in carrying out a physician recommendations, and the school recognizes the desirability of responding to the physician's request. This accommodation on the part of the school is not legally required, Therefore, the persons signing the form are agreeing to release the school and its personnel from any or all suits that might arise from the arrangements.

_____
Signature of both parents (or guardians if living with student) Address

Phone_____ Date_____

_____
Physician

Diagnosis or indication for medication_____

Precautions, if any_____

I would like a follow-up report by phone with the Nurse_____ Teacher_____ Principal_____
Psychologist_____ At the following intervals: Weekly_____Monthly_____ Quarterly_____

Please discontinue this request as of this date:_____
(After this date, a new form must be completed for changes or new orders.)

_____ _____ _____ _____
Signature of Physician License# Address Phone

Form: 3300-11-B