CAPROCK ACADEMY

CHARACTER. ACCOUNTABILITY. ACADEMICS.

REQUEST FOR PRESCRIPTION/OTC MEDICATION TO BE GIVEN AT SCHOOL

Name of Student	Grade	Date of Birth

Name of Medication	Dosage	Time(s) Each Day

Route	Date to Begin Medication	Date to End Medication

Expected Action of Medication/Side Effects (please write on the back of this sheet if additional space is needed or attach additional pages).

The undersigned understand and agree that the above medication may or may not be administered in accordance with the written instructions by non-nursing or medically licensed staff at Caprock Academy without direct assistance or supervision by the registered nurse or licensed health care providers at time of direct administration.

Signature of Doctor	Date

Signature of Parent/Legal Guardian	Date

Signature of School RN	Date

Notes/Comments:

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