



REQUEST FOR MEDICATION TO BE GIVEN AT SCHOOL

Name of School		
Name of Student	Date of Birth	Grade
Name of Medication	Dosage	Time(s) each day
Date to Begin	Date to End	
Medical Diagnosis		
Expected Action of Medication/ Medical Procedure/Side Effects/additional medication directions		

The undersigned understand and agree that the above medication may be administered by non-nursing staff of Caprock Academy in accordance with the above instructions.

Physician

Name	Telephone
Signature	Date

Physician Initials

Student understands the proper use of his/her medications, and in my medical opinion, can carry one dose of the above medication and use his/her medications at school independently with approval from school nurse.

Parent/Legal Guardian

<i>I hereby give permission for the school to administer the medication and treatments as prescribed above. I also give permission for the school to contact the above health care provider regarding the administration of this medication and share the above information with pertinent school staff.</i>	
Name	Telephone
Signature	Date