

Medication Stop Form

Student Name: _____

Student Date of Birth: _____

School: _____

Name of Medication: _____

Stop Date (required): _____

☐ Discontinue Medication: my child will no longer receive this medication at school

☐ Discontinue Medication at School: my child will take this medication at home

☐ Medication Change: my child will be taking a different medication (new consent/order form needed)

I hereby request MCVSD51's staff stop administering the medication(s) listed above to my student.

Parent Name (please print): _____

Parent Signature: _____ Date: _____

School Nurse _____

School Nurse Signature _____ Date: _____