REQUEST FOR MEDICATION TO BE GIVEN AT SCHOOL

I request that (child's name): _____ DOB: _____ Grade: _____

be allowed to take the following medication at school.

Medication must be in its original labeled container. ☐ Prescription ☐ Over the Counter

Reason for Medication: _____

Name of Medication: _____

Dosage to be given: _____

Frequency/Time: _____ Number of doses submitted: _____

Physician's Name (print): _____

*Physician's Signature: _____ *Required for OTC medications*

Parent/Guardian Signature: _____

Date: _____

* NOTE: Per Rockwood School District's Medication policy, prescription and over the counter medications require written instructions from an authorized prescriber. In lieu of the physician's written request, the District will accept a prescription label properly affixed to the medication. The request shall state: name of student, name of drug, dosage, frequency of administration, route of administration, and the name of prescriber. Your pharmacy can provide an extra-labeled bottle for school.

The physician may fax this order to school at: _____

Read the full Policy 2870: Administering Medicines to Students on the Rockwood website at www.rsdmo.org