Double Adobe School District No. 45

7081 North Central
McNeal, Arizona 85617
(520) 364-3041
FAX: (520) 364-6796

REQUEST FOR GIVING MEDICATION AT SCHOOL

I _____ request that my child,
(Parent or guardian name)

_____ be administered his/her prescription medication at school.
(child's name)

In the absence of the nurse/health-aid, I request that another staff member (i.e., teacher, school secretary), administer my child's medication as directed by his/her physician.

MEDICATION NAME_____

TIME(S) TO BE GIVEN _____

PHYSCIAN'S NAME _____ PHONE_____

CHILD'S TEACHER_____ GRADE_____

ALL PRESCRIPTION MEDICATION MUST BE IN A LABELED BOTTLE.

_____

PARENT SIGNATURE DATE