SAINT JOSEPH SCHOOL
DODGEVILLE, WI

REQUEST FOR SCHOOL MEDICATION

To be completed by physician:

Name of Student_____

Name of Medication_____

Amount to be given_____

Time of day to be given_____

Number of days to be given_____

Date_____ Signature of MD_____

To be completed by parent:

The medicine is to be furnished by the parent and is to be the original prescription bottle labeled with the name of the medicine, the amount to be given, time of day to be given, and the expected duration of the treatment. The physician's name must be on the label.

Name and address of physician:

_____
_____
_____

I hereby give my permission to the school to give the medication to my child according to the directions stated above. I further agree to hold the school and the personnel giving the medication harmless in any and all claims arising from the administration of this medication at school.

I agree to notify the school in writing when any change in the above orders is necessary.

Date_____Parent/Guardian Signature_____