MEDICATION REQUEST

_____   _____
Student's Name   Grade

_____   _____
Name of Medication   Purpose of Medication

_____   _____
Dosage to be given   Time to be given and for how long

Check one:

_____ School should keep container for duration of prescription
_____ School should return container home daily

_____   _____
Date   Parent/Guardian Signature

_____   _____
Date   Physician Signature

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