MEDICATION REQUEST FORM

This form is designed to assure parents and protect children in need of receiving medication during the school day of the appropriate handling of such needs. The school does not want in any way to discourage parents from dispensing or supervising medication to their children at school if they are able to do so, but is assisting only as an alternative.

Date: _____

Student's Name: _____

I hereby give my permission to the staff at Malta Elementary School to dispense medication prescribed

by Dr. _____

for my child, beginning _____; ending _____.

Name of medication, prescription number including drug store name:

_____

Dosage and special instructions for dispensing: _____

_____

If there are any side effects of this medication, please indicate:

_____

Physician's Signature: _____

I hereby release the school from any liability in administering this medication.

Parent's Signature: _____

Principal's Signature: _____

Date	Time	Dosage	Initials	Date	Time	Dosage	Initials