

FLANAGAN-CORNELL UNIT DISTRICT #74
Medication Request Form

Student's Name: _____

Name of Medication: _____

Dosage or Procedure required: _____

Times Required _____

Possible reactions that should be reported to the physician:

Special instructions including storage and sterile requirements:

Physician's Name (prescription medication only) _____

I, the parent/guardian, do authorize the school personnel to administer the medication or procedure as instructed above. I also agree to 1) Deliver the medication to the school; 2) notify the school if we change physicians; 3) notify the school if the medication, the dosage or the procedure is changed, or to be eliminated.

Signature if Parent/Guardian

Date

**This form must be signed by the student's parent/guardian in order for the student to receive any medication prescription and/or over the counter throughout the 2010-2011 school year.

Please send medications in the **original container only**, labeled with the student's name.