Prescription and Non-Prescription Medication Form

Student Name:_____ School Year: _____

School: _____ Grade: _____

Medication: _____

Dosage to be given:_____

Total daily dosage:_____

Starting date for medication: _____ Discontinue date for medication:_____

Reason for taking: _____

Possible side effects: _____

Allergies to past medications: _____

Physician Authorization

I request the above medication to be administered to the above student by the Francis Howell School District.

_____ _____
Physician signature Date

_____
Physician phone

Parent Authorization

I give my permission for this medication to be dispensed to my child at school. The school has my permission to call the physician with any questions regarding the medication.

_____ _____
Parent signature Date