RX MEDICINE REQUEST FORM

Student Name _____

Grade _____ DOB _____

Name of Medication _____

Dosage_____

Time to be given _____

Date to stop medication _____

Is medication to be kept at school or returned home? _____

Prescriber Signature _____Date _____

Guardian Signature _____ Date _____

RECORD OF DISTRIBUTION

Date	Time	Dose	Given By