DIOCESE OF SPOKANE
MEDICATION REQUEST FORM

Please Note: This form must be completed and signed by a physician, dentist, or a licensed health professional prescribing within the scope of his/her prescriptive authority and the parent. **This form is for both prescription and non-prescription medication.**

PARENT REQUEST

STUDENT NAME: _____

SCHOOL: _____

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student and request and authorize the school to dispense medication to the above identified student in accordance with the prescription of doctor's instructions for the period commencing with the _____ day of _____, 20 ____ through the _____ day of _____, 20 ____. I understand and agree that because of schedule and other responsibilities, a dosage or dosages may be delayed or missed.

_____ SIGNATURE: _____
Date of Signature

TELEPHONE NUMBER: _____
Home / Work

PHYSICIAN/DENTIST REQUEST

MEDICATION *(Name, Dosage):* _____

ADMINISTRATION SCHEDULE: _____

REASON FOR MEDICATION: _____

FURTHER INSTRUCTIONS *(possible reactions, etc.):* This section must be completed if medication is to be dispensed for more than 15 days.

I request and authorize that the above named student be administered the above identified oral medication in accordance with the instructions indicated above for the period commencing with the _____ day of _____, 20____ through the _____ day of _____, 20 ____ as there exists a valid health reason which makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials.

_____
Date of Signature

_____
Physician, Dentist, or a licensed health professional prescribing within the scope of his/her prescriptive authority Signature.

NAME: _____

TELEPHONE NUMBER: _____