Lind-Ritzville School District

209 E Wellsandt Ave Ritzville WA 99169

MEDICATION REQUEST FORM

Please note: This form must be completed and signed by the parent **and** the physician/dentist. This form is for both **prescription** and **nonprescription** medication. Complete a separate form for **each** medication. All medications must be transported to and from the school by a responsible adult.

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 or doctor's instructions for the period commencing: START DATE _____ TERMINATION DATE _____.

In the event of half-day school schedule, I want my child to take his/her medication at school: ____ Yes ____ No

_____ _____

Date Parent Signature

_____ _____

Home Phone Work Phone

LICENSED HEALTH CARE PROVIDER REQUEST

MEDICATION (Name, Dosage) _____

Please note: School staff can administer epinephrine by epi-pen auto-injector only.

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. _____

_____***STUDENT MAY CARRY INHALER ON PERSON***
_____***STUDENT MAY CARRY EPI-PEN ON PERSON***
_____***STUDENT MAY CARRY*** _____ ***ON PERSON***

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:
START DATE _____ TERMINATION DATE _____ 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 Physician/Dentist Signature

_____ _____

Office Phone Name (Please Print)