ALPINE INDEPENDENT SCHOOL DISTRICT

*Parent Request for Administration of (**circle one**)* **Prescription** **Non-Prescription**
By School Personnel

Please Print

Name of Student:_____ Date of Birth:_____

Name of Parent/Guardian:_____ Telephone #_____
During school Hours

Grade/Teacher:_____

Physician Name: _____ Phone #:_____

Condition Medication is being given for:_____

Name of Medication:_____ Prescription #_____
if prescribed medication)

Time to be given:_____ Dosage:_____

Name of Medication:_____ Prescription #_____
if prescribed medication)

Time to be given:_____ Dosage:_____

Period of time medication is to be given: _____Days _____Weeks _____Months _____PRN
As needed only

Special Instructions:

I CERTIFY THAT IT IS NECESSARY TO GIVE THE ABOVE MEDICATION DURING SCHOOL HOURS AND THAT IT IS PROVIDED IN THE ORIGINAL CONTAINER. THE SCHOOL NURSE/AIDE OR MEDICALLY UNTRAINED DESIGNATE OF THE SCHOOL MAY ADMINISTER THE MEDICATION.

Parent/Guardian Signature:_____ Date:_____

Clinic's Use Only:
Received By:_____ Date:_____