Maplewood Richmond Heights School District

Health Services

Request for Prescription and/or Over the Counter Medication to be Administered

Aligned with Board Policy JHCD

- ❑ This form must be completed at the beginning of each school year.
- ❑ Medication (prescription or over the counter) to be administered must be brought to school in a container appropriately labeled by the pharmacy or physician. Please have your pharmacist label two containers, one for school and one for home.
- ❑ Medication to be given at school is to remain at school for the period of time it is to be given.
- ❑ Medication stored in the school health office must be picked up from the school nurse by the parent or legal guardian at the end of the school year. No medications will be sent home with students.

Name of Student _____ **Date of Birth** ___ /___ /___ **Grade** _____

Teacher _____ Allergies _____

I request that the school nurse or trained staff member see that the following medication be administered to my child. The first dose of a new medication has been given at home. I release Maplewood Richmond Heights School District from the responsibility of any adverse side effects of this medication.

Name of medication (no abbreviations): _____

Dosage: _____ Frequency/Time(s): _____

Reason for medication/diagnosis: _____ Duration for medication: _____

Other medications currently being taken: _____

Additional instructions: _____

Physician/Licensed Prescriber's Name: _____ Phone: _____

I am the parent or legal guardian of the above-named student. I give employees permission to contact the student's physician about the student's condition. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication and for informing the school immediately if any information provided on this form changes, or if the administration of medication should cease.

Parent/Guardian signature: _____ Date: _____

Phone number(s): _____