METAMORA CCSD #1

Home Of The Redbirds

# ADMINISTERING MEDICINE AT SCHOOL

Please complete for **prescription or non-prescription medicine** to be administered to your child/children.

## DOCTOR'S REQUEST FOR ADMINISTERING MEDICINE AT SCHOOL

STUDENT'S NAME_____ BIRTHDATE_____

ADDRESS_____ SCHOOL Metamora CCSD#1

PARENT/GUARDIAN_____

SPECIFIC DIAGNOSIS_____

It is required that this medicine be given during school hours for the comfort and convenience of this child.

Name of Medicine_____

Dosage_____

Specific Directions_____

Possible Side Effects_____

_____ _____

Doctor's Signature Date

_____ _____

Office Address Phone

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## GUARDIAN REQUEST FOR ADMINISTERING NON-PRESCRIPTION MEDICINE AT SCHOOL

These non-prescription medicines may be administered at Metamora CCSD#1.

Medicines:_____

Children's Names:_____

Parent Signature:_____

Doctor's Signature:_____