# Marshalltown Community School District
## REQUEST FOR GIVING MEDICINE AT SCHOOL

Student's Name_____

School_____ Grade_____

Medical Diagnosis_____

Medication_____ Dosage_____ Route_____

Time to be given at school_____

Start date_____ End date_____

Other instructions or information_____

_____

Medication must be in bottle from the pharmacy with student's name and correct dosage instructions.
Only one medication per card.

_____ _____
Parent or Guardian Signature Date

_____ _____
Physician's Signature Date

Revision 4/11/08