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