ROYAL OAK SCHOOLS
A COMMUNITY OF EXCELLENCE

REQUEST FOR DISPENSING MEDICATION

Date

Student's Name

School

Address

Grade/Teacher

Name of medication: _____

Medication must be provided in the original pharmaceutical filled container whose label clearly indicates the physician's instructions for administration and the physician's name.

Reason for medication (optional): _____

Form of medication/treatment: ☐ Tablet/capsule ☐ Liquid
☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other: _____

Instructions (Schedule and dose to be given at school): _____

_____

Start: ☐ date form received Other dates: _____

Stop: ☐ end of school year Other date/duration: _____
☐ For episodic/emergency events only

Restrictions and/or important side effects: ☐ None anticipated
☐ Yes, please describe: _____

Special storage requirements: ☐ None ☐ Refrigerate ☐ Other: _____

This student is both capable and responsible for self-administering this medication:
☐ No ☐ Yes – Supervised ☐ Yes – Unsupervised

This student may carry this medication: ☐ Yes ☐ No

Please indicate if you have provided additional information:
☐ On the back of this form ☐ As an attachment

Physician Signature

Date

Address

Phone Number

☐ I request that the above named child receive the above medication at school according to school policy.

☐ I request that the above named child be allowed to self-administer the above medication at school according to school policy.

Parent/Guardian Signature

Date

Revised 11/2013