PALMYRA-EAGLE AREA SCHOOL DISTRICT
REQUEST FOR GIVING MEDICATION AT SCHOOL

The medicine is to be furnished by the parent and is to be labeled with the name of the medicine, the amount to be given, time of day to be given and the expected duration of treatment.

FOR NON-PRESCRIPTION MEDICATION:

I request that the designated school staff see that my child _____
Child's Name
receives the medication _____ for the period from

_____ to _____.
I agree to notify the school in writing at the termination of this request or when any change in medication occurs.

SIGNATURE OF PARENT/GUARDIAN _____DATE_____

FOR PRESCRIPTION MEDICATION:

I request that the designated school staff see that my child _____
Child's Name
receives the medication _____ for the period from

_____ to _____.
I agree to notify the school in writing at the termination of this request or when any change in medication occurs.

SIGNATURE OF PARENT/GUARDIAN_____DATE_____

TO THE PHYSICIAN: According to the State of Wisconsin Medical Examining Board and the School District, the following information must be completed in order for school personnel to dispense or administer medications.

Name of medicine _____
Amount to be given _____
Duration of treatment _____

Side effects that school staff should be aware of: _____
_____

I should be contacted regarding the following conditions of reactions of the above student who is receiving the medication(s) noted above: _____
_____

I am willing to accept direct communication from the person dispensing or administering the medication.

PHYSICIAN'S SIGNATURE _____DATE_____

PRINCIPAL'S SIGNATURE _____DATE_____