WINDSOR CENTRAL SCHOOL DISTRICT
HEALTH SERVICES

PHYSICIAN'S MEDICATION REQUEST (STATE REQUIREMENT)

Child's Name: _____ Date: _____

Date of Birth: _____

Diagnosis: _____

Medication: _____ To be given from _____ to_____

Dosage: _____ Frequency: _____

If PRN med, condition under which it may be given: _____

Medication may_____ (or) may not _____ be omitted for field trips

Medication can be adjusted so that the student can attend field trips. Yes_____ No _____

Student has been instructed and demonstrates competency to self- administer. Yes_____ No _____

Student may carry his/her own INHALER EPIPEN

Possible adverse reactions: _____

_____

Physician's Signature & Date

PARENTAL REQUEST FOR DISPENSING MEDICATION (State requirement)

I request that_____ receive the medication as prescribed above

1. Parent / guardian or other adult will deliver and pick up the medications personally. Medication will only be accepted in its original container.
2. All medications not picked up within 10 days of the conclusion of the prescribed period will be discarded.
3. Medications not picked up by the end of the last day of school will be discarded.
4. It is a violation of the Drug Free Schools Act for students to carry any type of medications unless approved by the School Nurse and Physician. Your child can be subject to disciplinary action.

I have read and understand the above procedures for my child to receive medicine in school. I understand that this applies to all medications including over the counter products such as Tylenol, cold medicines and topical ointments.

_____ _____

Parent/Guardian Signature Date