Dowagiac Union Schools

Medication Request and Authorization Form

2016-2017 School Year

Student Name:_____ DOB:_____
School: _____Grade:_____
Diagnosis/Reason for Medication: _____
_____

Medication	*Dosage*	*Time*	*Route*	*Special Instructions*

Student may self-carry EMERGENCY MEDICATION_____
Physician Signature

Physician Comments *(please list any probable side effects or restrictions):*_____
_____

_____

_____

_____ _____
Physician's (or Authorized Prescriber) Signature *Date*

Physician's (or Authorized Prescriber) Address:
_____

_____Phone_____

••••••••••••••

I have received and understand the Parent Guidelines for Medications at School. I request that my child be given the medications listed above according to the instructions listed, by an authorized staff member at school. I agree to notify the school in writing if the medication, dosage, schedule, or procedure is changed or eliminated, and to provide a new medication form if needed.

_____ _____
Parent Signature *Date*