

**ROSEVILLE COMMUNITY SCHOOLS**  
**STUDENT MEDICATION REQUEST**

NAME OF STUDENT: \_\_\_\_\_

GRADE: \_\_\_\_\_

TEACHER: \_\_\_\_\_

**PARENT REQUEST**

I am the custodial parent/legal guardian of the above student. I request that the school administer medication to my son/daughter as is stated in the Physician's Instructions portion of this form.

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

DAYTIME PHONE #/PAGER#/CAR PHONE#: \_\_\_\_\_

**PHYSICIAN'S INSTRUCTIONS**  
(PLEASE PRINT OR TYPE INFORMATION)

MEDICATION (GENERIC AND PROPRIETARY NAME): \_\_\_\_\_

CONDITION FOR WHICH TAKEN: \_\_\_\_\_

FORM IN WHICH SUPPLIED (I.E., 250 mg. TABLETS): \_\_\_\_\_

DESCRIBE, IN LAY LANGUAGE, HOW AND WHEN THE MEDICATION IS TO BE ADMINISTERED. (TECHNICAL TERMS AND ABBREVIATIONS ARE NOT ACCEPTABLE, AND NEITHER ARE TERMS SUCH AS "AS NEEDED"): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

WHAT SIDE EFFECTS MIGHT BE ENCOUNTERED, AND HOW SHOULD THE SCHOOL RESPOND?: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**THESE INSTRUCTIONS WILL BE IN EFFECT UNTIL \_\_\_\_\_ (DATE)**

PHYSICIAN'S NAME AND ADDRESS: \_\_\_\_\_

PHYSICIAN'S TELEPHONE NUMBER: \_\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**ATTACH CURRENT PHOTOGRAPH OF STUDENT TO THIS FORM**

