



REQUEST FOR MEDICATION TO BE GIVEN AT SCHOOL



I request that (child's name) _____
be allowed to take the following medication at school.

I am sending it in its original labeled container. (____ Prescription) (____ Over the Counter)

Reason for Medication _____

Name of Medication _____

Dosage to be given _____

Frequency/Time _____

Can the bottle stay at school _____ *Student CANNOT transport medication*

Physician's name (print) _____

*Physician's Signature _____ *Required for OTC medications*

Physician's phone number _____

Parent or Guardian Signature _____

Date _____

* NOTE: Per Rockwood School District's Medication policy, prescription and over the counter medications require written instructions from an authorized prescriber. In lieu of the physician's written request, the District will accept a prescription label properly affixed to the medication. The request shall state: name of student, name of drug, dosage, frequency of administration, route of administration, and the name of prescriber. Your pharmacy can provide an extra-labeled bottle for school. The physician may fax this order to school at 636-207-2584 (CCL's Intermediate Campus phone number 636-207-2579 ext 224 & Primary Campus 636-207-2551)

The medication policy is available at:

<http://www.rockwood.k12.mo.us/rsouth/support/medpolicy.htm>