WEST BRANCH – ROSE CITY AREA SCHOOLS

STUDENT MEDICATION REQUEST FORM

Part 1 (To be completed by parent / guardian)

*Student Name (First)*_____*(M. Initial)*_____*(Last)*_____

*Address*_____ *Homeroom Teacher*_____

_____ *Contact Telephone*_____

Grade _____ ☐ Male ☐ Female *Date of Birth* ____/____/_____

I hereby request the staff of the (choose one): ☐ *Surline Elementary School* ☐ *Surline Middle School* ☐ *Rose City School* ☐ *Ogemaw Heights High School to supervise the medication routine prescribed below for my child, named above. I understand that the directions of my physician (below) will be followed. I will notify the school of changes or discontinuation of this medication.*

I understand that I must bring the medication to the school in an original prescription bottle (see student handbook).

Parent Signature _____ *Today's Date*_____

Part 2 (TO BE COMPLETED BY PHYSICIAN)

Name of Medication _____ *Reason for Medication* _____

Dosage _____ *Frequency* _____ *Other Notes:*_____

Form of medication treatment = ( )tablet/capsule ( ) inhaler ( ) injection ( ) nebulizer ( ) other

Start: ( ) date form received ( ) other date _____
Stop: ( ) end of school year ( ) other date _____
( ) for episodic/emergency events only

Restrictions and/or important side effects _____
*Special storage requirements: ( ) none ( ) refrigerate ( ) other*_____

Physician Signature _____ ***Date*** _____

Please PRINT Physician Name_____
*Physician Contact Telephone Number*_____

Note: Parent should return the originally executed form to the school.

Part 3 (To be completed by the school)

*School Year*_____

Staff person supervising medication _____
Alternative staff person supervising medication _____
Location of medication _____

cc: *CA-60 and*
*Classroom teacher(s)*_____
_____
*Person supervising medication (named above)*_____

Record of Medication Dispensed is on Back of Form, or attached as a second page

RECORD OF MEDICATION DISPENSED

for Student Name_____Grade _____

1. **Name of Medication Dispensed**_____ **Amount**_____
   Date_____**Received by**_____
2. **Name of Medication Dispensed**_____ **Amount**_____
   Date_____**Received by**_____
3. **Name of Medication Dispensed**_____ **Amount**_____
   Date_____**Received by**_____
4. **Name of Medication Dispensed**_____ **Amount**_____
   Date_____**Received by**_____
5. **Name of Medication Dispensed**_____ **Amount**_____
   Date_____**Received by**_____
6. **Name of Medication Dispensed**_____ **Amount**_____
   Date_____**Received by**_____
7. **Name of Medication Dispensed**_____ **Amount**_____
   Date_____**Received by**_____
8. **Name of Medication Dispensed**_____ **Amount**_____
   Date_____**Received by**_____
9. **Name of Medication Dispensed**_____ **Amount**_____
   Date_____**Received by**_____
10. **Name of Medication Dispensed**_____ **Amount**_____
    Date_____**Received by**_____
11. **Name of Medication Dispensed**_____ **Amount**_____
    Date_____**Received by**_____
12. **Name of Medication Dispensed**_____ **Amount**_____
    Date_____**Received by**_____
13. **Name of Medication Dispensed**_____ **Amount**_____
    Date_____**Received by**_____
14. **Name of Medication Dispensed**_____ **Amount**_____
    Date_____**Received by**_____
15. **Name of Medication Dispensed**_____ **Amount**_____
    Date_____**Received by**_____

Report of Signification Information:

Date:_____**Information**_____

_____

Date:_____**Information**_____

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