MEDICATION REQUEST AND AUTHORIZATION FORM

Cassopolis Middle School
725 Center Street
Cassopolis, MI 49031
Telephone – 269.228.5836 Fax – 269.445.0505

Student's Name _____ DOB _____

School _____ Grade _____

Diagnosis/Reason for Medication _____

_____

_____

Medication	Dosage	Time	Route	Special Instructions

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

_____

_____

_____

_____ _____

Physician's (or Authorized Prescriber) Signature Date

Physician's (or Authorized Prescriber) Address _____

_____

Physician's (or Authorized Prescriber) Telephone _____

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/Guardian Signature Date