PARENT'S REQUEST FOR GIVING MEDICINE AT SCHOOL

Scurry-Rosser I.S.D.

I request school personnel see that my child, _____
Child's Name
be given this medicine _____ dose _____
prescribed by _____ starting _____
Physician's Name Date
for _____.
Length of time

The medication will be furnished by me and is labeled with my child's name, the name of the medicine, the amount to be given, and the number of times. I will add an approximate time of day the medicine should be taken and length of time my child may need to take this medication.

The principal and/or school nurse may call the doctor if there are any questions. **Medications that are prescribed three times a day can be given at home.** If there is a clear reason why the school personnel should give the medicine, please have the doctor ordering the medicine write that down.

INFORMATION MAY BE FAXED TO THE SCHOOL:
Elementary: 972-452-3434 Attn.: R. Rowe, R.N.
Middle School: 972-452-8902 Attn.: S. Hardy, R.N.
High School: 972-452-3694 Attn.: L. Charles, L.V.N.

Should school personnel feel that it is in the best interest of my child that the medication not be given on a certain day, they will notify me.

Reason for medication: _____

Time to be given: _____

Drug Allergies? : _____

ALL MEDICATIONS PRESCRIBED BY A DOCTOR MUST BE ACCOMPANIED WITH WRITTEN DOCTORS ORDERS.

Daytime phone number: _____

Signature: _____ Date: _____
Parent/Guardian