West Marshall Community School District
3rd Street N.W., P.O. Box 670
State Center, Iowa 50247

WEST MARSHALL COMMUNITY SCHOOL DISTRICT

REQUEST FOR GIVING MEDICATION AT SCHOOL

Student's Name _____ Grade_____

Teacher's Name _____ Bldg. _____

Medication _____

Time to be given _____ a.m. / p.m.

Date from _____ to _____

This medicine is furnished by parent or guardian with the regular label from the pharmacist, plus the name and strength of the medicine. This request must be signed by the parent/guardian and physician to authorize giving the medication during school hours.

_____ _____
Parent/Guardian Date

_____ _____
Physician's Signature Date

Significant Information:

Committed to Excellence