Prescription Medication Form

Name of Student

Grade

Name of Medication

Reason for Medication

Dosage

Length of Time to be Given

Time

Instructions for Administration

Route of Administration

Parent/Guardian Signature

Name of Physician

Date

***Please remind your child that he/she is responsible for asking for the medication at the appropriate time. The Board of Education of Diagonal Community School District and their designated representative are released from any liability concerning the giving or non-giving of the medication to the student.**

Other Comments:

Parents/Guardian Signature and Date