Holy Family
CATHOLIC SCHOOLS

REQUEST FOR PRESCRIPTION MEDICATION TO BE GIVEN AT SCHOOL

STUDENT INFORMATION

STUDENT NAME:	DATE OF BIRTH (MM/DD/YYYY):	
ADDRESS:	CITY:	ZIP:

MEDICATION INFORMATION

MEDICATION:	DOSAGE:	ROUTE:	TIME:

NOTE: School nurse and/or qualified personnel may give the first a.m. dose at school if necessary.

LENGTH OF TIME MEDICATION WILL BE REQUIRED:

DIAGNOSIS:	ICD-10 CODE:

ADMINISTRATION INSTRUCTIONS:

TO COMPLY WITH THE IOWA ADMINISTRATIVE CODE SECTION 281-41.12(11) ENTITLED "MEDICATION ADMINISTRATION," A LEGAL PRESCRIBER'S DESCRIPTION OF ANTICIPATED REACTIONS OF THE STUDENT TO THE MEDICATION MUST BE FILED AT THE SCHOOL. PLEASE LIST ANY ANTICIPATED REACTIONS:

PLEASE SIGN BELOW

I request that medication be given to the above student by the school nurse and/or qualified personnel.

In the event of an emergency, I give the school nurse and/or legal prescriber permission to communicate with one another regarding this medication and medical condition.

PARENT / GUARDIAN SIGNATURE _____ DATE _____

PRESCRIBER'S SIGNATURE _____ DATE _____

NOTE: This completed sheet must be at your child's school before any medication will be given.