Davenport School District, 801 7TH, Davenport, WA 99122 509-725-1261

MEDICATION REQUEST FORM

Please note: This form must be completed and signed by the parent and the physician/dentist. This form is for both prescription and nonprescription medication. All medication must be transported to and from the school by a responsible adult.

PARENT REQUEST

Student Name _____ Teacher _____ Grade _____

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student and request and authorize the school to dispense medication to the above identified student in accordance with the prescription or/ doctor's instructions for the period commencing:

Start Date _____ Termination Date_____

In the event of half-day school schedule, I want my child to take his/her mediation at school: Yes ☐ No ☐

_____ _____

Parent Signature/Date Contact Phone

LICENSED HEALTH CARE PROVIDER REQUEST

THIS PORTION TO BE COMPLETED BY THE PHYSICIAN/DENTIST

Name of Medication	Dosage	Method of admin	Time of day to take	PRN /Schedule
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Reason for the Medication: _____

Further Instructions (possible reactions, etc.): This section must be completed if medication is to be dispensed for more than 15 days.

Student MAY carry inhaler on person _____ Student MAY carry EPI-Pen on person _____

I request and authorize that the above named student be administered the above identified oral medication in accordance with the instructions indicated above for the period commencing:

Start Date _____ Termination Date _____ as there exists a valid health reason which makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials.

_____ _____

Please PRINT : Physician/Dentist **Physician/Dentist Signature**

Office: _____ Date: _____