



St. John-Hudson USD 350  
Request For Prescription Medication During School Hours

Student name: \_\_\_\_\_ DOB: \_\_\_\_\_

Allergies/Reaction: \_\_\_\_\_ School year: \_\_\_\_\_

Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_

Time of day medication is to be administered: \_\_\_\_\_

Anticipated number of days medication is to be administered at school: \_\_\_\_\_

Reason for RX: \_\_\_\_\_

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Date

I hereby request and give permission for the above named student to take the above named prescription medication at school as ordered. I understand that it is my responsibility to furnish this medication. I further understand that any school employee who administers any medication to my student in accordance with written instructions from the physician or dentist shall not be liable for damages as a result of an adverse reaction to the medication administered.

I hereby authorize USD 350 school nurse to exchange information regarding this request with the prescribing physician and with the pharmacy as identified on the affixed pharmacy label if clarification is required.

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Date

Note: Medication brought to school must be in the original container with all labels intact. Label must include pharmacy name, student name, medication name and dosage. If you are giving the medication at home as well, please request two medication containers from the pharmacy.