Prescription Medication

Request Form

Jamestown Area School District

Student Name _____ Birth Date _____

Home Room Teacher _____ Grade _____

Medication _____ Effective date _____ to _____

Dosage to be given at school _____

Hour(s) Time(s) medication is to be given _____

Purpose of medication / treatment _____

Possible reactions to medication _____

_____

Known allergies of student _____

_____

Procedure to follow if reaction to medication should occur _____

_____

_____

Does medication require refrigeration? Yes _____ No _____

Date _____ Requested by _____

Physician signature

Date _____ Requested by _____

Parent/Guardian prescription and non-prescription

Additional Comments _____

_____

_____

_____