



Welsh Hills
School

Request for Administration of Medication 2008-2009

Check all that apply:

- Non-Prescription Medication
- Prescription Medication
- Topical product or lotion

Complete all of the following information for a Non-Prescription medication or product:

Name of child: _____ Date of birth: _____ Weight: _____

Name of Medication or product: _____ Exact dosage: _____

To be administered at the following times: _____

For the following period of time: _____

Parent/Guardian signature: _____ Date: _____

Complete all of the following information for a Prescription medication or product:

_____ is under my care and should receive _____
(Name of child) (Name of medication or product)

as follows: _____
(include dosage and instruction)

Possible side effects to watch for are: _____

Signature of physician or dentist

Date of signature

Telephone number

Medication must be sent in its original container along with the child's name clearly marked. The school office keeps all medication in a secure location. Unused medication will be sent home at the end of the school year.