Fountain Hills Charter School

REQUEST FOR GIVING PRESCRIPTION AND OVER THE COUNTER MEDECINE

NAME OF CHILD _____

NAME OF PARENT/GUARDIAN_____

NAME OF MEDICATION _____ RX. NO. _____

TIMES OF DAY TO BE GIVEN _____ A.M. _____ P.M.

METHOD OF GIVING DOSAGE_____

AMOUNT OF EACH DOSAGE_____

DATE- From _____ To (must include) _____

REASON FOR MEDICATION_____

PERSON DESIGNATED TO ADMINSTER MEDICATION_____

PARENT/GUARDIAN SIGNATURE _____ DATE _____

DATE	TIME	STAFF SIGNATURE	COMMENTS