Date of Request: _____ School:_____ Grade/Teacher:_____
Student's Name: _____Birth Date: _____
Medication: _____ Dosage: _____
Is this the *INITIAL* dose of a *NEW* medication for your child YES NO
Time to be administered: _____ Dates to be Administered _____
Condition for which medication is required:_____
Special instructions/Precautions/Side Effects of medication for your child:

Physician Name: _____Phone: _____
Physician's Signature (if required) _____

My signature below indicates that I request PCSC/Saint Joseph Regional Medical Center Staff administer the medication specified above to my child and I am giving permission for PCSC/Saint Joseph Medical Center to contact the physician for additional information, if needed.
Parent/Guardian Signature: _____ Phone: _____
Date: _____

Documented in Health Office: _____ Date: _____
Office use only: Initial inventory

Date	# Pills	Counter's Signature

Medication returned to:
Signature: _____ Date: _____ Number returned: __