

# RACINE LUTHERAN HIGH SCHOOL

## Medication Request

Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Student's Address: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

<b>PARENT/GUARDIAN AUTHORIZATION</b>
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I, the parent/guardian of the above named student, request the medication listed below be kept/locked in the school office and given at school. I will notify the school in writing if there is a change or cancellation of the medication. I authorize release of this information to appropriate school personnel and classroom teachers.

_____	_____	_____
Name of Medication	Dose	Time(s) to Administer
Administer for:	<input type="checkbox"/> Full School Year	<input type="checkbox"/> Other _____

_____	_____	_____
Name of Medication	Dose	Time(s) to Administer
Administer for:	<input type="checkbox"/> Full School Year	<input type="checkbox"/> Other _____

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

