

**DES MOINES PUBLIC SCHOOL DISTRICT**  
**REQUEST FOR GIVING MEDICINE AT SCHOOL**

\_\_\_\_\_ should receive \_\_\_\_\_ at school.  
Student's Name Medication

I understand that I must:

1. Send the medicine to school in an original pharmacy container with a pharmacy label listing the child's name, the name of the medicine, the dosage, and the time to be given.
2. Sign this statement and return it to the school.
3. Provide a written statement from the physician and parent for student self administration of medication.

I further authorize the school nurse to contact my child's doctor to clarify orders specifically related to giving this medication.

\_\_\_\_\_ telephone #  
Doctor's Name

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

***This form must be renewed at the beginning of each school year if your child takes daily medication. Medication cannot be given without parent/guardian written consent.***

H:\Forms\Request for giving medicine at school.doc

Health Services Department

**DES MOINES PUBLIC SCHOOL DISTRICT**  
**REQUEST FOR GIVING MEDICINE AT SCHOOL**

\_\_\_\_\_ should receive \_\_\_\_\_ at school.  
Student's Name Medication

I understand that I must:

1. Send the medicine to school in an original pharmacy container with a pharmacy label listing the child's name, the name of the medicine, the dosage, and the time to be given.
2. Sign this statement and return it to the school.
3. Provide a written statement from the physician and parent for student self administration of medication.

I further authorize the school nurse to contact my child's doctor to clarify orders specifically related to giving this medication.

\_\_\_\_\_ telephone #  
Doctor's Name

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

***This form must be renewed at the beginning of each school year if your child takes daily medication. Medication cannot be given without parent/guardian written consent.***

H:\Forms\Request for giving medicine at school.doc

Health Services Department