Jamestown Area School District
Request Form

PRESCRIPTION MEDICATION

Student Name: _____ Date of birth: _____

Home Room Teacher: _____ Grade: _____

Medication	Dosage:	Frequency:	Time to be given:
1._____	_____	_____	_____

Purpose of medication: _____

Possible reaction: _____

Procedure to follow if reaction occurs: _____

Does this medication need refrigeration: yes___ / no___

Medication	Dosage:	Frequency:	Time to be given:
2._____	_____	_____	_____

Purpose of medication: _____

Possible reaction: _____

Procedure to follow if reaction occurs: _____

Does this medication need refrigeration: yes___ / no___

List all known allergies: _____

Physician signature: _____ Date: _____

Parent/Guardian signature: _____ Date: _____

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