

KIRTLAND SCHOOLS

Requests for Medications to be given on Field Trips and Tours

Student Name: _____

Grade: _____

Address: _____

Zip: _____

NON-PRESCRIPTION MEDICATIONS

TO BE COMPLETED BY PARENT / GUARDIAN:

I hereby request that the following non-prescription medications may be given:

Medications	Dosage	Frequency / Time of Day	Purpose

Dates to be given: _____

PRESCRIPTION MEDICATION

TO BE COMPLETED BY THE PHYSICIAN:

Medications	Dosage	Frequency / Time of Day	Purpose

Dates to be given: _____

Any possible reactions that, if they occur, should be reported to the physician: _____

Any special instructions: (storage, with food, etc...) _____

Physician Name: _____

Address: _____ Phone: _____

Physician Signature: _____ **Date:** _____

I request the above medication to be given to my child, as ordered by Dr. _____

Parent / Guardian Signature: _____ **Date:** _____

****Please note: Any medications brought in must be in the original, labeled container. ****