Bunker School District R-III

P.O. Box 365
Bunker, MO 63629

For the safety of our students, no medication will be given at school until the school receives a physician's written request for the administration of the medication by the school personnel with the prescribed medication in a container appropriately labeled by the pharmacy or physician, with only those doses to be given at school. A parent or guardian must also sign the request.

The following form may be used.

Your cooperation, as a parent, is greatly appreciated.

The following section is to be completed by the PARENT:

Child's Name: _____ _____ _____
Last First Sex Date of Birth

_____ _____ _____
Physician's Name Address Telephone

I request that my child be assisted in taking the medicine(s) described below at school by authorized persons or permitted to medicate herself/himself as also authorized by me and my physician (see below).

_____ _____ _____ _____
Date Parent/Guardian Signature Home Phone Emergency Phone

The following section is to be completed by the PHYSICIAN:

Diagnosis for which medication is given: _____

Name of Medicine _____

Form _____ **Dose** _____

If medicine to be given at school, at what time? _____

If medicine to be given PRN, describe indications _____

How soon can it be repeated? _____

Is child authorized to medicate herself/himself? _____

List significant side effects _____

Length of time this treatment is recommended _____

Other information _____

_____ _____
Physician's Signature Date