VICTORY CHARTER SCHOOL
PARENT REQUEST FOR DISPENSING MEDICINE AT SCHOOL

I request the teacher or other assigned adult to dispense medicines to my child during school hours.
STUDENT NAME: _____
The medicine is to be furnished by the parent or legal guardian. **It is to be in the original pharmacy bottle and the physician's name/label must be on it.**

Name of medication: _____Refrigerate? Yes No
Condition or Illness requiring medication: _____
Time(s) to be given: _____
Amount to be given: _____
Possible side effects: _____
Starting date: _____ Ending date: _____

Over-the-counter medications must be labeled with the student's name and dated.
Please leave in the original box or container.

I further assume the responsibility for informing the school of any change in health condition(s) or change of medication(s).

_____ _____
Signature of Parent or Guardian **Date**

MEDICATION LOG:

Date	Medication	Amount	Person Dispensing	Time