Exp date (2 weeks) _____

TULOSO-MIDWAY
INDEPENDENT SCHOOL DISTRICT

MEDICATION REQUEST FORM

STUDENT_____ DATE_____
GRADE _____

Dear Parent:
I will be happy to give your child his/her medication here at school. I do need the following information and signature before I can safely administer any medication.

Medication _____

Time to be give _____

Dosage _____

Number of days to be given _____

DATE	TIME	DOSE	SIGNATURE

Parent Signature _____ Date _____

Exp date (2 weeks) _____

Parent Signature _____ Date _____