

CONESTOGA ELEMENTARY SCHOOL

8404 42ND Street PO Box 40 Murray, NE 68409-00400

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"Conestoga inspires and prepares student for life"

REQUEST FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

I request that the administrator of his/her delegated authority administer the following

medication to _____
Name of Student

Name of medication and strength when applicable (for example: mg, grains)

Time medication is to be given

Amount of medication to give (for example: 1 capsule, 1 teaspoon)

Date medication to be given (specific date or "as needed" if needed for the school year)

Signature of parent/guardian

PLEASE SEND THE MEDICATION IN THE ORIGINAL CONTAINER FROM THE PHARMACY.

OVER THE COUNTER MEDICATION MUST ALWAYS BE SENT IN THE ORIGINAL BOTTLE OR CONTAINER.

FOR FURTHER SCHOOL POLICY REGARDING MEDICATION, PLEASE CONSULT THE PARENT/STUDENT HANDBOOK.

NO EXPIRED MEDICATION WILL BE GIVEN.