

Medication Release Form  
St. Francis of Assisi School  
West Des Moines, Iowa 50266

## Medication Release

Student \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_

Physician/Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Name of Medication \_\_\_\_\_ Pharmacy \_\_\_\_\_

Diagnosis \_\_\_\_\_

Please give the above medication:

Amount \_\_\_\_\_

Time \_\_\_\_\_

Starting Date \_\_\_\_\_ Ending date \_\_\_\_\_

Amount sent \_\_\_\_\_

I request that the prescribed drugs or medication be dispensed according to these written directions. I request that a qualified staff person give this medication. The student has experienced no previous side effects from the medication. I further agree that school personnel may contact the prescriber as needed and that medication information may be shared with school personnel who need to know.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

**MEDICATION WILL NOT BE GIVEN IF IT HAS EXPIRED OR IT HAS AN IMPROPER LABEL. PLEASE CHECK THE CONTAINER BEFORE SENDING IT TO SCHOOL.**

**SUGGESTION: WHEN YOU PICK UP YOUR CHILD'S PRESCRIPTION ASK YOUR PHARMACIST FOR A BOTTLE LABELED FOR SCHOOL USE.**