Print Form

PRESCRIPTION MEDICATION REQUEST: LONG TERM

STUDENT _____ ***SCHOOL*** _____

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- **I will notify the school immediately if the medication**

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HEALTHCARE PROVIDER STATEMENT:

_____

- **Medication** _____
- **Prescribed daily dosage** _____
- **Time and dosage given at school** _____
- **Beginning date of medication** _____ **Ending Date** _____
- **Possible side effects** _____

_____ _____

_____ _____

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