Prescription Medication Request: Long Term	
Student	School
	be in the original container indicating the following lealthcare provider, pharmacy, date issued, and
 I understand that in the absen personnel may administer med I agree to defend and hold the liability for the results of the magnetic forms. 	e school district employees harmless from any nedication or the manner in which it is and indemnify the school district and its employees these arrangements.
Home phone\ Other medications your child is taking	Date Work/ Emergency Phone g
to improve or maintain the health of this medication. The above named che following condition: • Medication • Prescribed daily dosage • Time and dosage given at sche • Beginning date of medication	T: This medication is required during school hours this student. The nurse may contact me regarding ild should receive prescribed medication for the
Printed Name	Date Phone