Prescription Medication Form
DAKOTA CUSD #201

Student:_____ DOB:_____ Grad Year:_____

Please fill out the form and sign in order for your student to take prescription medication. Medication must be in the original container. If you have any questions please call (844) 632-5682. Nurse Fax (815) 449-2459.

Medication:_____ **Dosage:_____** **Route:_____** **Condition:_____** **Time to Administer:_____**	**Medication:_____** **Dosage:_____** **Route:_____** **Condition:_____** **Time to Administer:_____**
Medication:_____ **Dosage:_____** **Route:_____** **Condition:_____** **Time to Administer:_____**	**Medication:_____** **Dosage:_____** **Route:_____** **Condition:_____** **Time to Administer:_____**

By signing below I give permission for the school nurse or those personswho have been properly trained, to administer medication(s).

_____ _____ _____

Printed Parent/Guardian Name Parent/Guardian Signature Date

_____ _____ _____

Printed Physician Name Physician Signature Date

Medication Administration Record
DAKOTA CUSD #201

Administrator Name:	Date:	Time: