



**Ilion Central School District  
MEDICATION REQUEST FORM**

**Ilion Jr. Sr. High School**  
PO Box 480  
Ilion, NY 13357  
Phone: 315-895-7471  
Fax: 315-895-7008

**Remington Elementary**  
77 East North St.  
Ilion, NY 13357  
Phone: 315-895-7729  
Fax: 315-894-2488

**Barringer Road Elementary**  
326 Barringer Road  
Ilion, NY 13357  
Phone: 315-894-8420  
Fax: 315-894-0153

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Home Address: \_\_\_\_\_

When your child's physician feels that medication is necessary during the school day, you are asked to follow certain procedures. School Nurses **cannot** administer medication to students without a written order from a physician. Therefore, you are requested to provide:

1. A written note from you, the parent or guardian (Part I below).
2. A written order from your physician or other health care provider including the information shown on this form (Part II below).
3. A new physician's order for each new medication or any change in medication dosage, time of administration, etc.
4. A new medication order at the beginning of each school year.
5. Bring the medication to school in the prescription bottle or original packaging if it is an over-the-counter medication.

Students are not allowed to carry medication of any kind on their person, or to take medication without written directive from physician and parent. When students are required to take any medication in school, it must be administered upon supervision.

**Part I: TO BE COMPLETED AND SIGNED BY PARENT OR GUARDIAN**

I hereby give permission for the medication to be administered to my child as stated below.

\_\_\_\_\_ (Student's name) \_\_\_\_\_ (Grade & Teacher or Homeroom)

\_\_\_\_\_ (Parent/Guardian Signature) \_\_\_\_\_ (Daytime Phone) \_\_\_\_\_ (Date)

**Part II: TO BE COMPLETED AND SIGNED BY HEALTH CARE PROVIDER**

\_\_\_\_\_ is to be given \_\_\_\_\_  
(Student's name) (Name of medication)

\_\_\_\_\_ (Dosage and frequency of medication)

for \_\_\_\_\_ (Diagnosis/Condition)

Possible side effects: \_\_\_\_\_

Purpose of medication: \_\_\_\_\_

\_\_\_\_\_ (Health Care Provider's Signature) \_\_\_\_\_ (Health Care Provider's Telephone)