950 Dover St. • Iowa City, Iowa 52245 • Phone 319-338-6061 • Fax 319-339-4465 • www.willowwind.org

20 - 20 Willowwind School Request to Administer PRESCRIPTION Medication in Preschool, School, B/ASP

Expiration Date____

Prescription medications can/may be administered at school only with a physician's written order (e.g. the prescription label) and written authorization from the parent or guardian as follows:

Date: ____________

Child's Name: ____

Medication: ____

Needed during school day? _____ Yes _____ No

Number of days to be given: ______________________ or as needed ________________

Dosage: _____________________ Give at: ______________________ Rx #:__________
AM PM

Side effects: ____

Special instructions: ____

Physician's Name: ____

Physician's Office & Phone Number ____

- ❑ **I have provided Willowwind School, Preschool, and B/ASP with my child's prescription medication.** It is in the original prescription container with his/her name attached. I request that authorized staff make provisions for my child to receive the medication as our physician has advised.

Signed: ____ Date: _____________________
Parent/Guardian Signature