

Health Network for Rural Schools
Medication Reminder Form

Dear Teacher: _____

Student Name: _____ **DOB:** _____

This student must receive medication in accordance to parents/physicians instructions.

- Please assist this student in receiving his/her medication by sending him/her to the office at _____ on a daily basis until _____.
(Time)

- Student is having difficulty remembering to come to the office for medications. Please help this student with a daily reminder to go to the office at _____.
(Time)

- Student has missed medication for the past _____ days. Your assistance is required to remind him/her to go to the office daily at _____.
(Time)

Cc: _____
RN

Cc: _____
Principal

Signature and Date