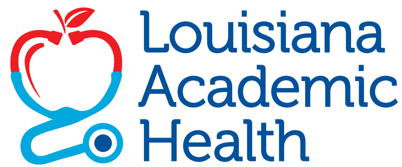

MEDICATION REFILL REQUEST

To the parent/guardian of ____

This letter is to inform you that as of ____________ *(date),* your child is out of his/her regularly administered

medication ____*(name of medication).* This medication

is administered daily during school hours to assist the student with *(benefits of medication administration):*

____

Please notify school clinic staff if you would like them to refill this medication for your child or if youplan to follow up with your child's primary care provider to have this medication refilled.

Please notify school clinic staff as soon as possible on your decision with this very important matter.

Louisiana Academic Health Network

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