CHICO UNIFIED SCHOOL DISTRICT
1163 E. SEVENTH ST., CHICO, CA 95928

Parent Request to Discontinue Medication

I, _____, request to discontinue medication listed below on
PARENT/GUARDIAN
the date indicated for my student _____ _____ .
NAME OF STUDENT DATE OF BIRTH

MEDICATION	**DATE DISCONTINUED**
_____	_____
_____	_____
_____	_____
_____	_____

I understand it is my responsibility to consult with my child's physician regarding the above change.

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

_____ _____
SCHOOL NURSE SIGNATURE DATE