REQUEST FOR MEDICATION TO BE ADMINISTERED BY SCHOOL NURSE

Student: _____ DOB: _____

Class of: _____

PARENTAL REQUEST

I, the parent/guardian of _____, request that the medication prescribed by my child's physician be administered to my child by the school nurse at the prescribed time.

I agree to bring a weekly supply of the medication to the school nurse. The medication will be brought to school in its original container appropriately labeled by my pharmacy.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Address Telephone #

PHYSICIAN'S STATEMENT

In order to protect the health of _____, it is necessary for him/her

Student's name

to have the following medication during school hours.

MEDICATION:

DOSAGE:

TIME TO BE ADMINISTERED:

PURPOSE OF MEDICATION:

LIST ANY POSSIBLE SIDE EFFECTS WHICH MIGHT BE EXPECTED:

_____

DIAGNOSIS:

_____

I authorize the school nurse to administer the above medication.

_____ _____

Signature of Physician Date

_____ _____

Print Physician Name Telephone #

_____

Street Address, City, State, Zip