REQUEST for MEDICATION to be ADMINISTERED by SCHOOL NURSE

Student: _____ **D.O.B.** _____

Grade: _____ **Teacher:** _____ **Room:** _____

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 **Phone #**

PHYSICIAN'S STATEMENT

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

_____ _____
Address **Phone #**