REQUEST FOR MEDICATION TO BE ADMINISTERED BY THE SCHOOL NURSE

Student name: _____

Date of birth: _____

Grade: _____

Classroom#/floor: _____

I, the parent/guardian of the above named student, request that the school nurse administer medication prescribed by the physician listed below. I agree to arrange for the supply of medications to be given to the school nurse.

_____

Parent/guardian signature(s) Date

Physician's Statement

In order to protect the health of the above named, it is necessary for her/him to have the following medication during school hours.

Diagnosis: _____

Medication: _____

Dosage: _____

Time to be administered: _____

Possible side effects that might be expected: _____

Next scheduled office visit: _____

_____

Physician Name Phone number

_____

Physician signature(s) Date

Form available at: http://globaltb.njms.rutgers.edu/educationalmaterials/productfolder/tbhandbook.html