REQUEST FOR MEDICATION TO BE ADMINISTERED BY A SCHOOL NURSE

Parental Request

Student _____ DOB_____ Grade_____ RM#_____

I, the parent/guardian of the above named, request that medication prescribed by a physician be administered to the above named by the School Nurse. I agree to arrange for the supply of medications to be given to the school nurse.

_____

Signature Address

_____

Date Phone

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.

Medication _____

Dosage _____

Time to be administered _____

Any possible side effects that might be expected _____

Purpose of Medication _____

Length of time medication is to be given prior to reevaluation _____

_____

DIAGNOSIS _____

I authorize the school nurse to administer the above medication.

_____

Signature Address

_____

Date Phone

Adapted from Jersey City School District, Jersey City, New Jersey.