

Request for Medication Administration 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 Districts, Jersey City, New Jersey.

Available in PDF format at: <http://www.umdnj.edu/ntbcweb/guide.html>