FORM 7020

REQUEST FOR MEDICATION TO BE ADMINISTERED BY SCHOOL NURSE

Student:	D.O.B.:	
Teacher:	Grade:	Room:

PARENTAL REQUEST

I, the parent/guardian of _____, I request that the school nurse administer the medication prescribed by my child's physician to my child 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 her/him to have the following medication during school hours.

Medication:
Dosage:
Time to be administered:
Purpose of medication:
List any possible side effects that might be expected:
Diagnosis:
I authorize the school nurse to administer the above medication.

Signature of Physician	Date
Print Physician's Name	Phone