

*Returns to Nurse in September*

**REQUEST FOR ADMINISTRATION OF MEDICATION DURING THE  
SCHOOL DAY**

**Student's Name** \_\_\_\_\_

**Age** \_\_\_\_\_ **Grade & Section** \_\_\_\_\_

**Address** \_\_\_\_\_

**Phone #** \_\_\_\_\_

**TO BE COMPLETED AND SIGNED BY THE PHYSICIAN**

**Diagnosis** \_\_\_\_\_

**Medication** \_\_\_\_\_

**Dosage** \_\_\_\_\_

**Duration** \_\_\_\_\_

**Side Effects** \_\_\_\_\_

**Physician's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**TO BE COMPLETED BY PARENT**

**I request that the school nurse administer the medication described  
above to my child** \_\_\_\_\_

**I will supply the school nurse with the medication prescribed in the  
original container or a duplicate professionally labelled and supplied  
by the pharmacist for this purpose.**

**Parent's  
Signature** \_\_\_\_\_