CONNERS-EMERSON SCHOOL

REQUEST FOR ADMINISTRATION OF MEDICATION IN SCHOOL

Student's Name: _____

Name of Medication: _____

Reason for Medication: _____

Dosage: _____ Time to be administered: _____

Duration of Medication: _____

Possible Side Effects: _____

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I am aware that the Conners-Emerson School has only one school nurse on staff who cannot provide personalized nursing services to all students. However, the above named student is in need of the above-named medication during regular school hours to maintain his/her physical health. In my opinion, the above-named medication is so important that if the school nurse is not available, I advise and request that the medication be administered by appropriately trained school personnel.

Parent Signature: _____ Date: _____

Physician Name: _____ Phone Number: _____

Physician Signature: _____ Date: _____

PLEASE NOTE: THIS FORM IS ONLY VALID FOR THE CURRENT SCHOOL YEAR.

FAX # 288-4706