

FLORENCE TOWNSHIP SCHOOL DISTRICT

Request for Medication Administration

1. Physician's Authorization:

Please administer to _____

Medication _____

Dosage _____ Time _____

Reason _____

Possible adverse reactions _____

Physician's Signature with Stamp _____

Date _____

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2. Parent/Guardian Authorization:

I, _____, request that the medication listed above be administered to my child at school. I understand that the school nurse or substitute school nurse will administer the medication. I will notify the school immediately if my child's health status changes or if there is a cancellation or change of this medication.

Parent/Guardian Signature _____

Date _____

3. All medication must be delivered to the school nurse by the parent or guardian in the original container provided by the pharmacy. Daily transportation of medication by the child ***is not permitted*** for safety reasons.