



*School Health Service
Huntington Public Schools
Huntington, New York 11743*

REQUEST FOR ADMINISTRATION OF MEDICATION DURING SCHOOL DAY

Student's Name: _____ D.O.B. _____

Address: _____ Tel# _____

School: _____ Grade: _____ Teacher: _____

Dear Parent/Guardian:

New York State Law will permit the administration of medication during the school day only with written directions from the physician and the parent.

On the reverse side of this letter, please find the medication form that must be filled out by you and your child's physician. Upon completion, please return this form with your child's medication in the original pharmacy container to the School Nurse's office.

A new form must be filled out for each change of medication and renewed each school year.

Please be informed that on an elementary level, students should never carry any medication of any kind on their person, nor should they take medication without official written directions from the physicians and the parent. Children should never take medication without supervision.

Sincerely,

School Nurse



REQUEST FOR ADMINISTRATION OF MEDICATION DURING SCHOOL DAY

1. TO BE COMPLETED BY PARENT/GUARDIAN

I request the school nurse to administer the medication as described below by my physician, to my child

(Name) _____

I will supply the school with the medication prescribed below, in the original container, or a duplicate professionally labeled by the pharmacist for this purpose.

(Parent/Guardian's Signature)

(Date)

2. TO BE COMPLETED AND SIGNED BY PHYSICIAN

Student's Name: _____ Diagnosis: _____

Name of Medication: _____

DOSAGE: Amount to be given: _____

Time to be given: _____

SIDE EFFECTS: To report: _____

To expect: _____

(Physician's Signature)

(Address)

(Date)

(Telephone)

