SOMERSET PUBLIC SCHOOLS

REQUEST FOR GIVING
OVER THE COUNTER AND PRESCRIPTION
MEDICATIONS AT SCHOOL

Date: ________________________

I request that the School nurse administer medication to my child (Name) _____________________________________, Grade ____, as prescribed by Dr. ______________________________ for the period from __________________ to ______________________.

Medication will be supplied by me and labeled with the original prescription label (if prescription medication), or the original container of the over the counter medication with the student's name and grade added.

Parent Signature: ____

To Be Completed by Physician or Nurse Practitioner for ALL Medication.

Medication: _________________________________

Dose: ______________________________________

Time: ______________________________________

Diagnosis: ___________________________________

Inhalers or EpiPens, please check one:

_____ Student to self-carry _______ Keep in Nurse's Office

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Physician Signature