SALEM COUNTY VOCATIONAL TECHNICAL SCHOOL DISTRICT

Health Services

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Request for Administration of Medication at School

Date: _____ Grade: _____

Student's Name: _____ Date of Birth/Age: _____

1. Diagnosis: _____
2. Student may attend school while on the medication: YES ☐ NO ☐
3. Name of medication: _____
4. Dosage and time of administration during school day: _____
5. Length of time medication to be administered at school: _____
6. May be excused from school-time dose on field trip or half day: YES ☐ NO ☐

Physician's Signature: _____

Physician's Phone Number: _____

Address/Office Stamp:

_____

Dear Parent/Guardian,

Please sign to indicate approval for the school nurse to administer this medication to your child as ordered. Your signature also gives the ordering clinician permission to share, discuss, and release the order with the school nurse.

Date: _____ Parent/Guardian signature: _____

Please note: Medication must be brought to school in its original container by parent/guardian.
Orders are valid only for the current school year.