REQUEST/PERMISSION TO ADMINISTER MEDICATION IN SCHOOL

(not including medical marijuana)

Student's Name	:	DOB:	Grade:	School:
A. To be comp	eted by Health Care Provi	ider:		
Reason for med	cation:			
Form of medica	tion/treatment:			
□ Tablet/capsule	e 🗆 Liquid 🗆 Inhaler 🗆 Injec	tion \square Nebulizer \square Oth	ner	
Dosage (amount	.):			
	must be administered durin			
If yes, time to b	e administered:			
	/or important side effects:			
\Box None anticipa				
\square Yes. Please de				
Date prescribed		Date to be discontin	ued:	
-				
IF APPLICAB		for colf oducinistania	this madiantic	r if allowed her Doord ralian
	pervised Yes - unsupervised		; this medicatio	n if allowed by Board policy.
	· · ·		$-\mathbf{N}_{-} = \mathbf{N}_{-}$	
	y carry this medication if all			• 41• 1• 4• 4
Note: The scho	of nurse may contact you i	if there are further qu	lestions concer	ming this medication request.
Health Care Pro	vider's Signature:			Date:
				mber:
Fax Number:				
		_ Email Address:		nission form.
Note: Any char	ges to the information abo	_ Email Address:		
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