AMAGANSETT UNION FREE SCHOOL DISTRICT
POB 7062, 320 Main Street
Amagansett, New York 11930-7062
Tel. (631) 267.3572/Fax. (631) 267.7504
Website: www.aufsd.org

School Medication Form

Student: _____

To: _____
(Name of school nurse)

I request that the above-mentioned student be given his medication during the course of the school day. This student _____ is under my
(Name)
care and treatment for _____.
(Name of condition requiring medication)

Name of medication: _____

Dosage: _____

Time of school medication: _____

Method of administering drug: _____

Side effects or possible reaction: _____
_____
_____
_____

Length of time student will be on medication: _____

Signature of Physician: _____
Name of Physician (print or type) _____
Address: _____
Telephone: _____
Date: _____

MJB/19