School year 200 - 200

HEALTH SERVICES DEPARTMENT
BERGENFIELD PUBLIC SCHOOLS

# STUDENT MEDICATION REPORT

_____ _____
Student's Last Name First HR/Grade

_____ _____
Student's Home Address Home Phone No.

_____ _____
Pediatrician/ Family Physician's Name Phone No.

I give my permission for the school nurse to give the medication named below to my son/daughter as directed by his/her physician. I shall notify the school nurse if there is any change in the medication.

Date: _____ Parent/Guardian Signature _____

## THE NEXT PART MUST BE COMPLETED BY THE PHYSICIAN/HEALTH CARE PROVIDER

Medical reason for the medication _____
_____

Medication _____ Prescribed dosage _____

Frequency _____ School time duration _____

Toxic or side reaction which may occur from this medication _____
_____

First aid in case of above reaction _____

_____

Additional information, comments, concerns : _____
_____

_____ _____
Physician's signature and stamp Date