

**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 _____