HANOVER TOWNSHIP PUBLIC SCHOOLS
HEALTH OFFICE

REQUEST FOR ADMINISTRATION OF MEDICATION BY THE SCHOOL NURSE OR A REGISTERED NURSE

Student Name: _____

Grade and Teacher: _____

Date: _____

In order to protect the health of the above-mentioned student it is necessary for him/her to have the following medication during school hours. I certify that he/she is physically fit to attend school and free of contagious disease.

Medication _____

Dosage _____

Time to be administered _____

Purpose of medication _____

Length of time prescribed _____

Possible side effects _____

All medications must be in the original prescription bottle.
A new form must be filled out whenever the dosage or medication is changed.
Medication request forms must be updated annually.

_____ _____

Parent/Guardian Signature/Date Physician's Signature/Date