Livingston PUBLIC SCHOOLS

REQUEST FOR MEDICATION TO BE ADMINISTERED BY SCHOOL NURSE

Physician's Statement

In order to protect the health of _____
it is necessary for her/him to have the following medication during school hours:

Diagnosis: _____

Purpose: _____

Medication: _____

Dosage: _____

Time: _____

List any side effects that can be expected: _____

_____

I authorize the school nurse to administer the above medication.

Physician's Signature: _____ Date: _____

Physician's Name (please print): _____

Parental Permission

I authorize my physician and his staff to release the information required to complete this medication form so my child can receive medication during school hours. I authorize the school nurse to administer the above medication to my child _____ as directed by my physician.

Signature of Parent/Guardian: _____ Date: _____

Parent/Guardian Name (please print): _____