HANOVER TOWNSHIP PUBLIC SCHOOLS
HEALTH OFFICE

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

Student: _____ **Class:** _____ **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 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