HANOVER TOWNSHIP PUBLIC SCHOOLS

Health Office

Request for Administration of Medication

By the School Nurse or a Registered Nurse

Student: _____ **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 the above-mentioned student 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