Verona Public Schools
Medical Department

REQUEST FOR MEDICATION TO BE ADMINISTERED BY SCHOOL NURSE
All information must be completed before the medication is dispensed.

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: _____

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): _____