Verona Public Schools
Medical Department
REQUEST FOR MEDICATION TO BE ADMINISTERED BY SCHOOL NURSE

All information must be completed before the medication is dispensed.

Health Care provider's Statement

In order to protect the health of _____it is necessary for them to have the following medication during school hours:

Diagnosis: _____

Medication (Generic and/or Brand Name) : _____

Purpose of Medication: _____

Dosage: _____

Route: _____

Time: _____

List any side effects that can be expected: _____

_____

I authorize the school nurse to administer the above medication.

Signature of Health Care provider: _____ Date: _____

Health Care provider's Name (please print): _____

Health Care Provider Stamp:

Parental Permission

I authorize my Health Care provider and 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 Health Care provider.

Signature of Parent/Guardian: _____ Date: _____

Parent/Guardian Name (please print): _____