BEVERLY
CITY SCHOOL DISTRICT

REQUEST FOR ADMINISTRATION OF MEDICATION

Student Name _____ **DOB** _____ **Date**_____

TO: Parents/Guardians
FROM: Dr. Elizabeth Giacobbe, Superintendent/Principal

In response to your request for your child, named above, to receive medication during school hours, kindly have his/her physician complete the information listed below, Sign the parental request statement, and return to the school nurse.

The administration of medication to pupils shall be done only in exceptional circumstances wherein the pupil's health may be jeopardized without it.

I hereby request that the above named student shall be administered medication as prescribed below:

DIAGNOSIS: _____

NAME OF MEDICATION: _____ **DOSAGE** _____

TIME TO BE ADMINISTERED _____

SIDE EFFECTS, ETC., TO BE OBSERVED FOR: _____

TO BEGIN ON: _____ **TO CONCLUDE ON:** _____

CAN OMIT ON FIELD TRIP DAYS: YES **OR** NO

SIGNATURE OF PHYSICIAN _____ **DATE** _____

I request that the school nurse administer the above medication to my child, as prescribed. I shall deliver the appropriate amount of medication to the school.

SIGNATURE OF PARENT/GUARDIAN _____

DATE: _____