Newgrange School
*An extraordinary place to learn*

The Laurel School
*of Princeton*

# REQUEST FOR ADMINISTRATION OF MEDICATION IN SCHOOL

## Student Information

Name_____ Homeroom Teacher _____ Grade: _____

Parent/Guardian Names(s) _____

Daytime Phone#:_____ Alternate Phone#: _____

List Student Allergies: _____

List Student Medications: _____

Diagnosis: _____

## Medication Information

Name of Medication: _____

Dose: _____ Start Date: _____ End Date: _____

Time(s) to be administered: _____

Route: _____ Orally _____Inhaled _____Injected _____Other

*Medication must be submitted to the school nurse by the parent/guardian in the original pharmacy labeled container.

*Medication must be picked up at the end of the school year or be discarded.

## Consent

Medications should be administered a home whenever possible. The nurse may administer medications in the health office when it is necessary to support health and safety in school.

Physician's Signature: _____

Physician Name (Stamp/Print): _____

I request the nurse administer the above medication.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Printed Name: _____ Relationship: _____

***Request to administer medication terminates automatically at the end of the school year.***
***Please return this form to the School Nurse.***