BRIDGEWATER-RAYNHAM REGIONAL SCHOOL DISTRICT
HEALTH SERVICES

Parents Request For Giving Medication At School
Special Medication Situation

For **Short-term over the counter** medication (i.e. those requiring administration for ten days or less).

I request the nurse or designated school personnel see that my child:

_____ _____
(child's name) (date of birth)

_____ _____
(school) (grade)

Receives medication prescribed by _____

For the period from _____ to _____

The medication is to be supplied by me and is to be in a pharmacy labeled container with the name of the child, the type of medication, mode of transmission, amount and the time of day to be given. I have been advised by my physician of all known harmful side effects and benefits of this medication.

THE FOLLOWING INFORMATION AND SIGNATURE BELOW ARE REQUIRED:

_____ _____
(name of drug) (parent/guardian signature)

_____ _____
(dose) (home telephone number)

_____ _____
(frequency) (emergency telephone number)

_____
(date)

My child is currently taking the following medications:

_____

Any known drug allergies: _____