

**BRIDGEWATER-RAYNHAM REGIONAL SCHOOL DISTRICT
HEALTH SERVICES**

**Parents Request For Giving Medication At School
Special Medication Situation**

For **Short-term prescription** medication (i.e. those requiring administration for ten school 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:
