

# 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:

\_\_\_\_\_