

Seneca Valley School District
Private Physician Request For
Administration of Medication During School Hours
School Year _____

Dear Health Care Provider:

The purpose of this form is to give the school nurse direction on medications that must be administered during the school day. Medication is defined as prescription, over the counter medications and other therapeutic agents. *This form must be completed and signed by the parent and the physician or dentist before it will be accepted by the school nurse.*

Please include the following information:
1. Name of Student 2. Amount of medication to be taken 3. Time medication is to be taken

Name of Student _____ Grade _____ Homeroom _____

Medication	Dosage	Time	Duration (current school year or lesser period as stated)	Reason
1.				
2.				
3.				
4.				
5.				

Instructions/Observations:

Curtailment of Specific School Activities: No_____ Yes_____ (please explain)

Physician Signature Date

Printed Physician Name or Stamp

Phone Number

I authorize this medication to be administered to my child:

Parent/Guardian Signature Date

School Nurse Date Received