



Bethlehem Central School District  
700 Delaware Ave.  
Delmar, NY 12054  
(518) 439-4921  
<http://bcsd.k12.ny.us>

**REQUEST FOR MEDICATION TO BE ADMINISTERED  
BY SCHOOL PERSONNEL**

Student's name: \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

Address: \_\_\_\_\_

Name of medication to be administered: \_\_\_\_\_

Condition for which medication is ordered: \_\_\_\_\_  
\_\_\_\_\_

Dosage: \_\_\_\_\_

Frequency: \_\_\_\_\_

Length of time to be given: \_\_\_\_\_

Special instructions: \_\_\_\_\_  
\_\_\_\_\_

Physician's Stamp or Printed Name \_\_\_\_\_

**PHYSICIAN'S SIGNATURE**

**DATE**

\_\_\_\_\_

\_\_\_\_\_

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***This section to be completed by the parent/guardian.***

Because the school nurse is not always in the school building, we have other school personnel instructed in the administration of oral medications. Therefore, we ask that parents indicate, from the personnel listed below, which school staff members have permission to provide oral medication to their child(ren).

**Medication to be administered by:** *[Check only one.]*

( ) School nurse only

( ) School nurse or trained aide

**PARENT/GUARDIAN SIGNATURE**

**DATE**

\_\_\_\_\_

\_\_\_\_\_

*This form must be filled out completely and returned to the nurse's office at your child's school in order to provide the necessary information and safety precautions for the student's benefit.*

**INJECTABLE MEDICATION WILL BE ADMINISTERED  
BY THE SCHOOL NURSE ONLY.**