



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

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.**