F 20

BURLINGTON SCHOOL DISTRICT

Request for Administering Medication by School Personnel
(To be submitted to the Health Office)

Name of Student____

School__________________________________ Grade______________

Medication____

Dosage____

Directions____

Reason for giving____

______________________ ________________________________
Date Signature of Parent or Guardian

______________________ ________________________________
Date Signature of Parent or Guardian

[No medication will be given at school until the school receives this completed form with the necessary signatures and the prescribed medication in a container appropriately labeled by the pharmacy or physician.]

FOR PRESCRIPTION MEDICATION ONLY

I hereby request that ______________________________ be given the above prescription at school as ordered.

Date________________________ ____________________________
Signature of Physician

Special Instructions____

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~~9/96