LEVITTOWN PUBLIC SCHOOLS
DEPARTMENT OF HEALTH SERVICES
REQUEST FOR ADMINISTRATION OF MEDICATION
DURING SCHOOL DAY

STUDENT'S NAME: _____
DOB_____
HOME ADDRESS:_____ Zip_____
TELE.#:_____
SCHOOL:_____ Grade_____
HOMEROOM_____

***PLEASE NOTE: A 1" X 1" a current head shot photo of your child is required which will be attached to his/her medication card in order to facilitate the safe administration of medication.**

DEAR PARENT OR GUARDIAN:

Every effort should be made to administer medication at home, as it does represent a disruption in the student's school day.

However, if your physician feels that medication is necessary during the school day, please submit this completed form before medication is sent to school.

A new form must be filled out for each change of medication and renewed each school year. State law does permit administration of medication during the school day - only with written directions from the physician and parent. In some instances, approval by the school physician may be required. Students may not take medication without official written directive (from the physician and parent) or to take medication without supervision.

Donald Donald Sturz
Assistant Superintendent for Pupil Services

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1. TO BE COMPLETED BY PARENT OR GUARDIAN

I request the school to administer the medication as described below by my physician to my child, (Name) _____.
I will supply the school nurse with the medication prescribed below in the original container, or a duplicate,
professionally labeled by the pharmacist for this purpose.
DATE:_____
SIGNATURE:_____
RELATIONSHIP TO
STUDENT:_____

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2. TO BE COMPLETED AND SIGNED BY PHYSICIAN:

Student's Name_____
DIAGNOSIS_____
Medication
Name:_____
Dose:_____
Route:_____
Time/Frequency_____ If PRN,
Frequency_____
Duration of Administration:_____
Possible Side Effects:_____

SIGNATURE OF PHYSICIAN_____

PHYSICIAN'S STAMP_____ DATE_____