

BURLINGTON SCHOOL DISTRICT

Request For Administering Medication By School Personnel
(To be submitted to the building principal)

NAME OF STUDENT _____

SCHOOL _____ GRADE _____

MEDICATION _____

DOSAGE _____

DIRECTIONS _____

REASON FOR GIVING _____

DATE

SIGNATURE OF PARENT/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 _____
