

AMAGANSETT UNION FREE SCHOOL DISTRICT
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School Medication Form

Student: _____

To: _____
(Name of school nurse)

I request that the above-mentioned student be given his medication during the course of the school day. This student _____ is under my
(Name)
care and treatment for _____.
(Name of condition requiring medication)

Name of medication: _____

Dosage: _____

Time of school medication: _____

Method of administering drug: _____

Side effects or possible reaction: _____

Length of time student will be on medication: _____

Signature of Physician: _____

Name of Physician (print or type) _____

Address: _____

Telephone: _____

Date: _____