## HUNTINGDON AREA SCHOOL DISTRICT PRIVATE PHYSICIAN REQUEST FOR ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

The parent/guardian of _		has requested that
the school administer medication	n(s), namely	
	to the student during ti	ie school day.
I understand that it is the request that medication be given		ngdon Area School District to ours whenever possible.
In those cases where it is school hours, the following infor		t receive the medication(s) during e.
NAME OF MEDICATIO	ON(S)	
DOSAGE		
HOW TO BE ADMINIST	TERED(ORAL/INJECT	TION)
TIME OF ADMINISTRA	ATION	
DURATION OF MEDIC	ATION ADMINISTRA	TION
POSSIBLE SIDE EFFEC	CTS/CONTRAINDICTION	ONS
		TIVITY (SPORTS, SHOP,
		YSICIAN THAT STUDENT
IS STUDENT CAPABLE	E OF SELF-ADMINIST	RATION ?
Date	Signate	ure of Physician
	Physic	ian's Telephone No.
Thank you for your coop	eration.	
		ure of School Nurse
	Signat	ure
FORM A – 1966		
2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Signat	ure