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(s), namely _____ _____ to the student during the school day.

I understand that it is the procedure of the Huntingdon Area School District to request that medication be given before or after school hours whenever possible.

In those cases where it is essential that the student receive the medication(s) during school hours, the following information must be complete.

NAME OF MEDICATION(S) _____

DOSAGE _____

HOW TO BE ADMINISTERED(ORAL/INJECTION) _____

TIME OF ADMINISTRATION _____

DURATION OF MEDICATION ADMINISTRATION _____

POSSIBLE SIDE EFFECTS/CONTRAINDICTIONS _____
_____

CURTAILMENT OF SPECIFIC SCHOOL ACTIVITY (SPORTS, SHOP, LAB, DRIVER'S TRAINING, ETC.) _____

OTHER MEDICATIONS PRESCRIBED BY PHYSICIAN THAT STUDENT IS TAKING OUTSIDE OF SCHOOL _____

IS STUDENT CAPABLE OF SELF-ADMINISTRATION ?_____

_____ _____
Date Signature of Physician

_____
Physician's Telephone No.

Thank you for your cooperation. _____
Signature of School Nurse

_____
Signature

FORM A – 1966

_____
Signature