

SCOPE Manhasset Summer Center

Date: _____

Re: Parent’s Request for Administration of Medication in School

Dear School Nurse:

I request that my child _____ who is in grade_____ receive the medication as prescribed below by our licensed health care provider. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication. Furthermore, I understand it is my responsibility to immediately notify the Health Office of any change in the type, dosage, or frequency of administering the medication.

Signature (Parent or Guardian): _____

Address: _____

Telephone: Home _____ Work _____

Prescribed by Dr. _____

Name of Medication: _____

Dose to Be Given: _____

Time/Frequency to Be Given: _____

Number of Days to Be Given: _____

Diagnosis: _____

Physician’s Signature: _____

Physician’s Stamp: _____

Phone Number: _____

IF YOU WANT MEDICATIONS AVAILABLE FOR YOUR CHILD, THIS FORM MUST BE COMPLETED PRIOR TO THE START OF SUMMER CENTER.

PLEASE RETURN WITH MEDICATIONS TO SUMMER CENTER NURSE at MUNSEY PARK SCHOOL ON JULY 6, 2010 FROM 9:00am to 12noon.