HANOVER TOWNSHIP PUBLIC SCHOOLS HEALTH OFFICE

REQUEST FOR ADMINISTRATION OF MEDICATION BY THE SCHOOL NURSE OR A REGISTERED NURSE

Student: _		Class:	Date:	
81				
In order to p	protect the health of the above	e-mentioned	student it is necessary	for him/her to
have the fol	lowing medication during sol	nool hours.	I certify that he/she is	physically fit
	hool and free of contagious d		•	
	ş -			
	Medication			
	Dosage			
	Time to be administer	ed		
	Purpose of medication	A 	TILLETO CONTRACTO CONTRACTO	
	Purpose of medication Length of time prescribed			
	Possible side effects		100	
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** A 11 1	medications must be in orig	inal preser	intion hottle	n 24
	ew form must be filled out		-	on is changed
	dication request forms must		_	on is changed.
1720	areation request forms mus	. be update	u annuany.	
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	<i>E</i>			
Pare	Parent/Guardian signature/Date		Physician's signature/Date	