Swedesboro-Woolwich School District
Woolwich NJ 08085
WRITTEN REQUEST FORM FOR
ADMINISTRATION OF MEDICATION

Name of Student: _____ Date: _____

Date of Birth _____/ _____/_____ Age: _____ Grade: _____

Please Print

1. Diagnosis:

   _____

2. Student may attend school while on medication: YES: _____ NO: ____

3. Name of Medication: _____

4. Dosage and time of administration while attending school:

   _____

5. Length of time medication is to be administered at school: _____

Physician Signature _____ Telephone # _____

Parent/Guardian:

Please sign to indicate your approval of your child receiving the medication at school and of the School Nurse administering the medication to your child

Signature of Parent: _____

Date: _____

Note: Medication **MUST** be brought to school in original container by a responsible adult and the not student.