ENGLEWOOD PUBLIC SCHOOL DISTRICT
274 KNICKERBOCKER ROAD
ENGLEWOOD, N.J. 07631

REQUEST FOR DISPENSING MEDICATION AT SCHOOL

TOP PORTION FOR PYSICIAN/NURSE PRACTITIONER ONLY

Child's Physician/Nurse Practitioner Complete:

Date_____

STUDENT NAME_____
DIAGNOSIS_____
MEDICATION_____
DOSAGE_____
TIME TO BE GIVEN_____
DATE ORDERED_____DATE DISCONTINUED_____
NURSE PRACTITIONER/PHYSICIAN (print)_____
NURSE PRACTITIONER/PHYSICIAN (signature)_____
ADDRESS_____
TELEPHONE NUMBER_____

Parent/Guardian Complete:

I _____ give permission for the School Nurse to
Print parent/guardian name/nombre

give_____ to _____.
Medication & Dosage **Student Name**

Child (has) (has not) taken this medication in the past.
El/la niño/a (ha) (noha) tomado esta medicina anteriormente

_____ _____
Parent/guardian signature/firma Date/Fecha