Phone:Fax:	
Student's Name: Grade: Date of Birth:	٠.
Student's Name:	
Weight:lbskg (if needed for dosage) Allergies:	
Parents/guardians must provide medication to School Nurse in the original, unopened container labels student's name and homeroom. All medications must be hand delivered to the School Nurse by an adult, a student. Check all medications that may be given and specify dose and frequency in the chart below. If you p that no over-the-counter medications be administered to your child at school, please check the box be medication. Reason Dose Route Frequency Medication Reason Dose Route Frequency Ibuprofen/ Motrin	
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Please note School policy does not permit the student to self-carry the over-the-counter medica	ffinara,
☐ I do not wish my child to receive any over-the-counter medications at school. (No Doctor's Signature is rec	quired.)
LI A WO LLOW PERSON AND ADDRESS OF THE PARTY	
ent/Guardian Signature: Phone:	
etor's Signature: Date: Phone:	
nool Nurse Signature: Date: Phone:	