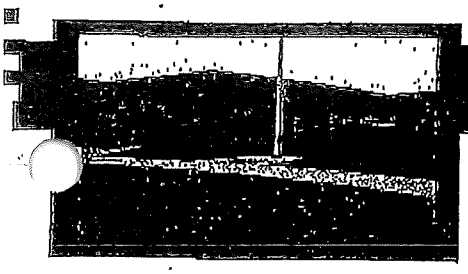


Riverside Elementary East

School and Kreig
Streets Moosic, PA

Principal, Mrs. Nicole VanLuvender
Phone: (570) 342-7171
Fax: (570) 341-8298

PRIVATE PHYSICIAN REQUEST FOR ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS.

Dear Doctor:

The parent/guardian of _____
had requested that we administer the following medication to the student during school hours. It is our procedure to request that medication be given before or after school hours whenever possible. If it is essential that the student receive the medication during school hours, please complete the following information.

NAME OF MEDICATION _____

DOSAGE TO BE GIVEN _____

ROUTE OF ADMINISTRATION _____

TIME OF ADMINISTRATION _____

DURATION OF ADMINISTRATION _____

POSSIBLE SIDE EFFECTS _____

REASON FOR MEDICATION _____

CAN CHILD SELF ADMINISTER MEDICATION _____

OTHER MEDICATIONS BEING TAKEN _____

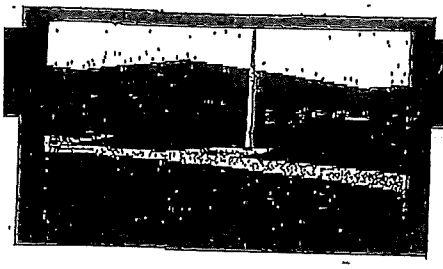
_____ _____

PHYSICIAN SIGNATURE DATE

_____ _____

SCHOOL NURSE SIGNATURE PHYSICIAN PHONE NUMBER

PLEAE RETURN TO SCHOOL NURSE'S OFFICE AS SOON AS POSSIBLE. NO MEDICATION CAN BE ADMINISTERED WITHOUT A PHYSICIAN'S ORDER AND CONSENT FROM THE PARENT. THANK YOU FOR YOUR COOPERATION IN THIS MATTER.



Riverside Elementary East

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PARENT REQUEST FOR MEDICATION ADMINISTRATION DURING SCHOOL HOURS.

I REQUEST AND GIVE MY PERMISSION TO THE SCHOOL NURSE TO SEE THAT MY CHILD

_____
STUDENT NAME

RECEIVES THE FOLLOWING MEDICATION _____
NAME OF MEDICATION

PRESCRIBED BY MY DOCTOR _____ FOR
PHYSICIAN NAME

THE PERIOD FROM _____ TO _____

FOR THE FOLLOWING ILLNESS _____.

I UNDERSTAND THAT THE MEDICATION MUST BE BROUGHT TO SCHOOL BY THE PARENT OR APPOINTED ADULT REPRESENTATIVE OF THE STUDENT. THE MEDICATION MUST BE LABELED BY THE PHARMACY TO INCLUDE NAME OF STUDENT, NAME OR MEDICATION, AMOUNT OF MEDICATION TO BE GIVEN, THE TIME MEDICATION IS TO BE GIVEN, AND THE PHYSICIAN'S NAME. NO MEDICATION CAN BE GIVEN WITHOUT THE PHYSICIAN ORDER AND PARENT CONSENT.

_____ _____
SIGNATURE OF PARENT/GUARDIAN **DATE**

_____

I HAVE RECEIVED THE FOLLOWING AMOUNT OF MEDICATION RETURNED TO ME BY THE SCHOOL NURSE.

_____ _____
MEDICATION AMOUNT RETURNED

_____ _____
PARENT/GUARDIAN SIGNATURE SCHOOL NURSE SIGNATURE

_____
DATE