Butler High School
38 Bartholdi Avenue, Butler New Jersey, 07405
Telephone: 973-492-2000 Fax-: 973-492-8672   www.butlerboe.org

REQUEST FOR MEDICATION ADMINISTRATION BY A SCHOOL NURSE

Student's Name______________________________Date of Birth_____________________

Parent/Guardian's Name______________________Telephone #______________________

To Be Completed By Physician

I certify that the above named student has the illness specified below, is physically fit to attend school, and is free of contagious disease. I further certify that the student will not be able to attend school if the medication is not administered during school hours.

Name of Illness____

Name and Purpose of Medication____

Prescribed Dosage and Time to be Taken_____________________________________

Medication to Start:___________________**Medication to Stop:**____________________

Possible Side Effects:____

Physician's Name__________________________**Telephone#**_____________________

Physician's Signature________________________________**Date**___________________

To be Completed by Parent or Guardian

I request that the School nurse administer to ______________________________________
the medication prescribed by the Physician listed above.

Signature of Parent/Guardian____________________________Date__________________