

**BURLINGTON PUBLIC SCHOOL
HEALTH PROGRAM**

**Burlington School District
Request for Administering Medication by School Personnel
To be submitted to the BHS Health Office**

Name of Student _____

School _____ Grade _____

Medication _____

Dosage _____

Directions _____

Reason for giving _____

Date _____ Signature of Parent/Gaurdian _____

No medication will be given at school until the school receives the completed form with the necessary signatures and the prescribed medication in a container appropriately labeled by the pharmacy or physician.

FOR PRESCRIPTION MEDICATION ONLY

I hereby request that _____ be given the above prescription at school as ordered.

Date _____ Signature of Physician _____

Name of Physician (please print) _____

_____ My child may carry his/her inhaler with them during school hours.