

LAKE SHORE CENTRAL SCHOOLS



Health Services Department

In compliance with the requirements of the New York State Department of Education relative to INTERNAL MEDICATION by SCHOOL PERSONNEL, we hereby request the School Nurse to follow the instructions in the treatment of:

STUDENT NAME: _____

DIAGNOSIS: _____

PARENT / GUARDIAN SIGNATURE: _____

NAME OF MEDICATION: _____

**DOSE AND
FREQUENCY** _____

TIME OF ADMINISTRATION: _____

SPECIAL INSTRUCTIONS: _____

HEALTH CARE PROVIDER NAME: _____

(Please Print Name Clearly

HEALTH CARE PROVIDER SIGNATURE: _____

DATE: _____

