

## Attachment I

### SEASHORE MIDDLE ACADEMY PARENT'S REQUEST FOR ADMINISTRATION OF MEDICATION

DATE: \_\_\_\_\_

I, the undersigned, who is the parent / guardian of \_\_\_\_\_, \_\_\_\_\_,  
Student's Name Date of Birth

request the following medication(s) to be administered to my child.

MEDICATION	DOSAGE	TIME	REFRIGERATION	START DATE	STOP DATE
			YES / NO		
			YES / NO		
			YES / NO		

I understand that the school administrator will appoint a qualified designated person to perform the above mentioned health care service.

I will notify the school immediately if the health status of \_\_\_\_\_ changes, we change  
Student's Name  
physician, or the dosage is changed or cancelled.

Signature of parent / guardian \_\_\_\_\_

Address \_\_\_\_\_

Phone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Pager \_\_\_\_\_ Cell Phone \_\_\_\_\_