SEASHORE LEARNING CENTER
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 _________________________________