

Pawtucket School Department

School Administration Building
P.O. Box 388, 286 Main Street, Pawtucket, RI 02860
(401) 729-6300 Fax: (401) 727-1641 TDD: (401) 729-6338

MEDICATION REQUEST FORM

ADMINISTERING MEDICINE IN SCHOOL

A student who must take medication during school hours is required to have a medication request form completed and returned to the school nurse-teacher. New requests must be filled out by the parent/guardian at the beginning of each school year. Medication will be held and dispensed by the school nurse-teacher. The medication must be in the original container with the following information:

Child's Name	Physician's Name
Name of Medication	Strength of Medication
Dose and Time to be Given	

Note: Different medications and doses **MUST NOT** be combined in the same container.

Please have the following information filled out by the physician:

NAME OF STUDENT: _____

SCHOOL: _____

PHYSICIAN'S NAME: _____ TELEPHONE NUMBER: _____

DIAGNOSIS: _____

NAME OF MEDICATION: _____

STRENGTH OF MEDICATION: _____

DOSE AND TIME TO BE ADMINISTERED: _____

PERIOD OF ADMINISTRATION: (DATE) _____ TO (DATE) _____

MEDICATION MAY BE OMITTED DURING FIELD TRIPS YES _____ NO _____

POSSIBLE SIDE EFFECTS: _____

ASTHMA INHALERS: Student may self-administer inhaler YES _____ NO _____

Student may self-carry inhaler YES _____ NO _____

SIGNATURE OF PHYSICIAN DATE

I hereby give permission for the Pawtucket School Department School Nurse-Teacher to Administer the above noted medication to my child.

SIGNATURE OF PARENT OR GUARDIAN DATE

Revised 3/07

The Pawtucket School Department does not discriminate on the basis of age, sex, race, religion, national origin, color or disability in accordance with applicable laws and regulations.

Departamento Escolar de Pawtucket
Predio de Administração Escolar
P.O. Box 388, 286 Main Street, Pawtucket, RI 02860
(401) 729-6300 Fax: (401) 727-1641 TDD: (401) 729-6338

FORMULARIO DE MEDICAMENTO

ADMINISTRANDO MEDICAMENTO ESCOLA

Todos os estudantes que toman medicamentos durante as horas da escola, requeremos que preencham um formulario e devolvam-no a enfermeira da escola. O novo formulario deve ser preenchido pelos pais/guardiaes no comeco do an escolar. Os medicamentos ficarao na pose da enfermeira e serao adminstrados por el na escola. Os medicamentos devem estar no recipiente original com as instrucoes a seguir.

Nome da crainca

Nome do Medico

Nomne do Medicamento

Dosagem do Medication

Dose e hora que deve ser dado

Nota: Doses e diferentes medicamentos NAO DEVEM estar combinados no mesmo recipiente.

Por favor peça ap medico para preencher estas informacoes:

NAME OF STUDENT: _____

SCHOOL: _____

PHYSICIAN'S NAME: _____ TELEPHONE NUMBER: _____

DIAGNOSIS: _____

NAME OF MEDICATION: _____

STRENGTH OF MEDICATION: _____

DOSE AND TIME TO BE ADMINISTERED: _____

PERIOD OF ADMINISTRATION: (DATE) _____ TO (DATE) _____

MEDICATION MAY BE OMITTED DURING FIELD TRIPS YES _____ NO _____

POSSIBLE SIDE EFFECTS: _____

ASTHMA INHALERS: Student may self-administer inhaler YES _____ NO _____

Student may self-carry inhaler YES _____ NO _____

SIGNATURE OF PHYSICIAN DATE

Eu dou permissao para para a enfermeira do Departamento Escolar de Pawtucket administrar o medicamento acima indicado para a minha crianca.

ASSINATURA DOS PAIS E GUARDIOES DATA

Revisto 3/07

O Departamento Escolar de Pawtucket nao discrimina idade, sexo, raca, religiao, origem nacional, cor ou desabilidade fisica de acordo com as leis e regulamento do estado.

Departamento Escolar de Pawtucket

Edificio de Administración Escolar
P.O. Box 388, 286 Main Street, Pawtucket, RI 02860
(401) 729-6300 Fax: (401) 727-1641 TDD: (401) 729-6338

FORMULARIO PARA PEDIDO DE MEDICAMENTO

ADMINISTRANDO MEDICAMENTOS EN LA ESCUELA

Un estudiante que debe tomar medicamentos durante el día escolar se le requiere que tenga una formulario de permiso completado y debe ser entregado a la enfermera escolar. La solicitud para tomar medicamentos en la escuela debe ser completada por un padre ó tutor todos los años al principio del año escolar. El medicamento estará y será administrado por la enfermera escolar. El medicamento debe estar en su envase original y debe tener la siguiente información

Nombre del estudiante	Nombre del Médico
Nombre del medicamento	Fortaleza del Medicamento
Dosis y la hora que se debe administrar	

Nota: **NO SE DEBE** combinar diferentes medicamentos en el mismo envase.

Por favor de pedirle al doctor que llene la siguiente información:

NAME OF STUDENT: _____

SCHOOL: _____

PHYSICIAN'S NAME: _____ TELEPHONE NUMBER: _____

DIAGNOSIS: _____

NAME OF MEDICATION: _____

STRENGTH OF MEDICATION: _____

DOSE AND TIME TO BE ADMINISTERED: _____

PERIOD OF ADMINISTRATION: (DATE) _____ TO (DATE) _____

MEDICATION MAY BE OMITTED DURING FIELD TRIPS YES _____ No _____

POSSIBLE SIDE EFFECTS: _____

ASTHMA INHALERS: Student may self-administer inhaler YES _____ NO _____

Student may self-carry inhaler YES _____ NO _____

SIGNATURE OF PHYSICIAN

DATE

Por este medio le doy permiso a la Enfermera Escolar del Departamento Escolar de Pawtucket para administrar el medicamento mencionado arriba a mi hijo.

FIRMA DEL PADRE O TUTOR

FECHA

REVISADO 3/07

El Departamento Escolar de Pawtucket no discrimina en las bases de edad, sexo, raza, religión, Nacionalidad, color o incapacidad en acuerdos con las leyes y regulaciones aplicables