PARSIPPANY TROY-HILLS TOWNSHIP SCHOOLS

REQUEST FOR ADMINISTRATION OF MEDICATION

My child _____, date of birth _____, is in need of _____ medication during school hours/school sponsored events. I am requesting that the above medication be administered to my child as described in the written Health Care Provider's order, and according to Parsippany Troy-Hills district policy.

This request is valid for the _____ school year only.

_____ _____
Principal's Signature Date

_____ _____
Nurse's Signature Date

_____ _____
Parent's Signature Date