Shenango Area School District

Health Services

Julie Hudak CRNP, FNP-C, CSN
High School Nurse
724-658-5537 ext. 3700
Fax 724-658-7584

THIS FORM MUST BE COMPLETED FOR PRESCRIPTION MEDICATION TO BE ADMINISTERED AT SCHOOL

Student Name_____ DOB_____

Prescription Medications to be taken at school require **BOTH** physician signature and parental/guardian signature. . The prescription must come in a Pharmacy Labeled container. Medication cannot be given unless these requirements are met.

Medication Name_____ Dose_____

Route_____ Administration Time: morning lunchtime afternoon (circle one)

Diagnosis (Reason for medication)_____

Special Instructions:

Date_____ Physician Signature_____ Telephone #_____

Date_____ Parent/Guardian Signature_____ Telephone# _____

Controlled Substances must be brought in by an adult. We request that parents/guardians of elementary students bring all medications to school.