School District Name:__________________________School Name: _____________________

Individual's Name: _____________________________________

School Mailing Address (No PO Boxes / Signature Required): _______________________________________

City:_________________________State:____________Zip Code: _____________________

Phone: ____________________________________

Program: Seizure Rescue Medication Training for School Employee volunteers

Amount: $25.00

Please return form to Carolyn Croxall, email ccroxall@utah.gov

Cards will be sent to the school. Signature is required upon delivery.

Finet: 1000-270-4359-LEJ

____ ____________________

Signature **Date**

____ ______________________________

School Nurse (Printed) **School Nurse Signature**

12.8.20