PERMISSION FORM FOR PRESCRIBED MEDICATIONS

Dear Parent:

New York State Regulations prohibit the administration of medication in public schools unless a written directive is on file with the school from a physician and the parent. This form serves that purpose. In cases where a child must have medication during hours which school is in session, this form must be completed by the physician and parent, and returned to the School Health Office. It is also required that the medication itself must be in its original regular prescription container with the directions visible and attached to the container.

Thank you, and if you need any further assistance, please call the School Health Office by dialing 251-2000.

Student Name ____

To be completed by the physician or authorized prescriber:

Reason for medication:____

Name of medication:____

Form of medication/treatment:

____

Tablet_________ Liquid_________ Inhaler________ Other_________

Instructions (Schedule and dose to be given at school)

____

Start:___________ Date form received__________ Other date______________________________________

Stop: __________ Date_____________ For Episodic/Emergency events only

Restrictions and/or important side effects None anticipated_________

YES – Please describe

____

____

Special storage requirements NONE_________ REFRIGERATE__________

This student will be taking their medication in the Health Office under the supervision of Mrs. Frasier

This student, if a 7th grader or older, may carry and use an inhaler as needed: YES_________ NO__________

Physician's Name ____________________________ Phys. Signature _____________________________

To be completed by parent/guardian:

I give the above named student permission to take the above medication at school in accordance with school policy and all applicable regulations. The medication will be in its original container.

Parent Signature____