

**\* THIS FORM IS FOR STUDENTS REQUIRING MEDICATION TO BE HELD IN THE HEALTH OFFICE AND ADMINISTERED BY THE SCHOOL NURSE**

**ROSLYN PUBLIC SCHOOLS  
ROSLYN, NEW YORK 11576**

Department of Health, Physical Education and Recreation  
**PERMISSION FOR ADMINISTRATION OF MEDICATION IN SCHOOL**

Dear Parent:

The State law requires that we have the following information for any student who must take medication in school:

\_\_\_\_\_  
Name of Student

\_\_\_\_\_  
Address

\_\_\_\_\_  
Teacher

\_\_\_\_\_  
Grade

\_\_\_\_\_  
School Nurse

**TO BE FILLED OUT BY PHYSICIAN**

\_\_\_\_\_  
Name of Student

is to take

\_\_\_\_\_  
Medication

\_\_\_\_\_  
Duration of Therapy

\_\_\_\_\_  
Dosage

\_\_\_\_\_  
Time Route

\_\_\_\_\_  
Diagnosis

\_\_\_\_\_  
PRN or Scheduled?

Side effect of this medication are: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Stamp Required

\_\_\_\_\_  
Telephone Number

**TO BE FILLED OUT BY PARENT**

I HEREBY GIVE PERMISSION TO THE School Nurse or designee to administer the above medication according to the

above instructions to \_\_\_\_\_

\_\_\_\_\_  
Name of Student

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date