ROSLYN PUBLIC SCHOOLS
ROSLYN, NEW YORK 11576

Department of Health, Physical Education and Recreation

PERMISSION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

Dear Parent(s)/Guardian(s):

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 ________ Medication ______________________

Duration of Therapy __________ Dosage __________ Time ________ Route ________

Diagnosis: ______________________________ PRN or Scheduled? ______________

Side effects of this medication are____

____

Address of Physician ______________________ Signature of Physician ______________ Date ________

Telephone Number of Physician ______________________ Name of Physician (Printed) ______________________

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 instruction to

____
Name of Student

______________________ ________
Signature of Parent or Guardian Date