*** 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 is school:

_____ _____

Name of Student Address

_____ _____ _____

Teacher Grade School Nurse

TO BE FILLED OUT BY PHYSICIAN

_____ is to take _____

Name of Student 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