

SCHOOL HEALTH SERVICES
WAPPINGERS CENTRAL SCHOOL DISTRICT

Brinckerhoff SCHOOL

PARENT PERMISSION FOR IN-SCHOOL MEDICATION

Student _____ Grade ____ Room ____ ID# _____

Date: _____

I hereby give permission to the school nurse or designated school personnel to administer _____ as prescribed by the physician. (Physician prescription attached.)

This medication is to be administered as ordered during the current school year. Any changes to the medication order from the physician will be given, in writing, to the school nurse.

I hereby give permission to the school nurse or designated school personnel for appropriate communication with the ordering prescriber related to the above medication.

I have furnished the medication in a properly labeled original container from the pharmacy. I have provided the medication in the dosage ordered.

I hereby release the school nurse or designated school personnel and the Board of Education of any liability relative to the administration and/or reaction of the medication on the above named student.

Parent/Guardian Signature

Home phone _____

Work phone _____

Cellular Phone _____

Beeper _____

Times and dosage of any and all medications taken at home

