SCHOOL HEALTH SERVICES
WAPPINGERS CENTRAL SCHOOL DISTRICT

MEDICATION FORM

Date: _____

Student Name: _____ DOB:_____ ID # _____

Diagnosis: _____

Name of Medication: _____

Dosage: _____

Frequency: _____

Time/s to be given: _____

Medication Expiration Date_____

PLEASE CIRCLE YES OR NO

Yes □ No □ I attest that this student has demonstrated that he/she can self-administer the medication listed above effectively and may carry and use this medication independently at any school/school sponsored activity. Staff intervention and support are needed only during an emergency.

****** Physician Stamp REQUIRED ******

Physician Signature: _____

Physician Name: _____

Parent/Guardian Permission for Medication

_____ I agree that my child can self-administer and will carry the medication as prescribed above.

_____ I give permission to have the School Nurse/designated school personnel administer the prescribed medication as above.

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 _____ Date: _____