ROSLYN PUBLIC SCHOOLS
ROSLYN, NEW YORK 11576

HS-8
HEALTH SERVICES

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

_____ is to take _____
Name of Student 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 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 instructions to _____
Name of Student

_____ _____
Signature of Parent or Guardian Date