RONDOUT VALLEY CENTRAL SCHOOL
PUPIL PERSONNEL SERVICES/HEALTH SERVICES
PO BOX 9, ACCORD, NY 12404

MEDICATION PERMISSION REQUEST FORM

In accordance with State Education law, this district requires that all students who need medication during school hours must do the following:

1. Present a written consent form signed by the health care provider stating what medication is needed, the dosage, and when the medication is to be given.
2. Present written consent from parent for student to receive medication as prescribed by health care provider.
3. Bring the medication in the original container, with pharmacy/ package label, to health office personnel.

Parents may request that the pharmacist dispense two bottles of medication, one for home and one for school.

NAME OF STUDENT_____

DATE OF BIRTH_____ **SCHOOL**_____

TO BE COMPLETED BY HEALTH CARE PROVIDER

NAME OF MEDICATION:_____

DOSAGE:_____

SPECIFIC TIMES TO BE GIVEN:_____

LENGTH OF TIME:_____

ARE THERE ANY RESTRICTIONS? _____YES _____NO
IF YES, WHAT AND HOW LONG? _____

_____ _____
PRINTED NAME OF PROVIDER **SIGNATURE OF PROVIDER**

_____ _____
DATE

_____
ADDRESS

TO BE COMPLETED BY PARENT/ GUARDIAN

I, _____, give permission for my child to receive the above medication as directed.

_____ _____
DATE **PARENT'S/GUARDIAN'S SIGNATURE**

_____
TELEPHONE

DH13a; 03/14

RONDOUT VALLEY CENTRAL SCHOOL

Name_____DOB_____Provider_____

Medication_____Dose_____Frequency_____

Day	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June
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2										
3										
4										
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