

**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**

\_\_\_\_\_  
**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**

DH13a; 03/14

\_\_\_\_\_  
**TELEPHONE**

**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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3										
4										
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