EAST MORICHES UNION FREE SCHOOL DISTRICT
9 Adelaide Avenue
East Moriches, NY 11940

PERMISSION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

Dear Parent:

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 _____ Dosage _____ Time/Frequency _____ Route _____

Diagnosis _____ Duration of Therapy _____

Side effects of this medication are _____

Address of Physician _____ Signature of Physician _____ Date _____

Telephone Number of Physician _____ 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/Guardian _____ Date _____