HICKSVILLE PUBLIC SCHOOLS

MEDICATION PERMISSION

NAME _____ AGE _____

SCHOOL _____ GRADE _____

Dear Parent:

In order for any medication to be taken in school., state law requires a written request from your family physician including frequency, the dosage and the side effects of the medication. The school nurse MUST also have on file a written request from the parent to administer medication. A new form must be filled out for each change of dosage.

TO BE COMPLETED BY AND SIGNED BY THE PHYSICIAN:

Specific diagnosis _____

Name of Medication _____

Duration of regimen _____

Dosage - Amount to be given _____

Time to be given _____

Side effects to expect/report _____

Date _____ Physician's Stamp:

Signature of Physician _____

TO BE COMPLETED BY PARENT OR GUARDIAN:
I request that the school nurse administer the medications requested by my physician to my child. I understand that I must deliver the medication directly to the school nurse in a container labeled by the pharmacist and this will include the name of the medication.

Signature of Parent or Guardian _____

Relationship to Student _____ Date _____

IMPORTANT: Please submit a small picture of your child (a school photo would be excellent) to attach to the medication which is maintained in the nurse's office. This is to ensure that your child's medicine is always given to your child. This is especially important for the occasion when a substitute nurse is in the building. Your assistance in responding to this is greatly appreciated. If you have any questions please call the school nurse to discuss the situation. Thank you.

Rev. 4/05