Windsor School

127 State Street
Windsor VT 05089
Phone: 802-674-9822 Fax: 802-674-9803

PRESCRIPTION MEDICATION ORDER AND PERMISSION FORM

Date_____

I hereby give my permission to _____(Physician) to release information concerning my child _____to WCUD School Nurse re: his/her medical condition and the medication prescribed for it; and for the school nurse to communicate with the physician as to any response we may see at school. This information will be held confidential except on an educationally needed basis.

Signature of Parent or Guardian_____

****

Medication _____
Directions for use _____
Beginning Date _____ Ending Date_____
**All prescribed medication must be renewed each school year.*
Reason for giving_____
**For asthma inhaler, please indicate if his can self administered _____yes ____no*

Signature of Physician_____

****

I hereby give permission for the above named student to take the medication as prescribed above at school.

Signature of Parent or Guardian _____

****

No medication will be given at school until the school has received this completed form with the medication in a container appropriately labeled by the pharmacy or physician. All medication brought to the school must be kept in the Health Office.

Date Received _____

Signature of School Nurse_____