Phoenix Central School District

MEDICATION ADMINISTRATION PERMISSION FORM

Student Name _____ Grade _____ DOB _____

NAME OF MEDICATION _____

DOSE _____ Time to be given: _____

Duration _____ Reason for Medication _____

Diagnosis _____

I give permission for the above prescribed medication to be administered to my child by school personnel while in school and on school field trips.

Signature _____ Phone _____

PHYSICIAN'S SIGNATURE _____ Phone: _____

*****INHALERS ***** Doctor's authorization to allow above named patient to **carry** prescribed inhaler and use as needed during the school day.

Doctor's permission to carry inhaler on person: _____

****

I give permission for the above prescribed medication to be administered to my child by school personnel while in school and on school field trips.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

PER THE SCHOOL DRUG POLICY - - PLEASE BE AWARE THAT STUDENT'S ARE NOT ALLOWED TO BE IN POSSESION OF ANY UNAUTHORIZED MEDICATIONS (including OVER THE COUNTER medications such as TYLENOL) WHILE IN SCHOOL. IF THEY ARE FOUND TO BE IN VIOLATION OF THE DRUG POLICY, THEY WILL RISK DISCIPLINARY ACTION.

School Nurse
Pre K – 4
MAM Elementary
11 Elm Street
Phoenix, NY 13135
Phone: 695-1563
Fax: 695-1620

School Nurse
Gr. 5 – 8
EJD Middle School
116 Volney Street
Phoenix, NY 13135
Phone: 695-1524
Fax: 695-1523

School Nurse
Gr. 9 – 12
JCB High School
552 Main Street
Phoenix, NY 13135
Phone: 695-1634
Fax: 695-1694