

MAMARONECK UNION FREE SCHOOL DISTRICT HEALTH SERVICES
MEDICATION PERMISSION SHEET

Dear Parent/Guardian:

New York State Law provides that internal medication should not be administered in school. However, on occasion, your child may require medication during school hours. In such instances, the following requirements must be met:

1. Written signed orders from the child's physician
2. A written request from the parent/guardian
3. The medication should be brought to school in the original labeled bottle. (Please ask the pharmacist for an extra bottle or container).

Please complete the following form and return it to the school nurse. Thank you for your cooperation.

NAME OF CHILD:

DOB:

GR: TEACHER: _____ WEIGHT: _____ lbs.

DIAGNOSIS: Allergy: _____

NAME OF MEDICATION: Antihistamine (Name): _____

DOSAGE & ROUTE OF ADMINISTRATION: give _____ mg by mouth/orally

TIME TO BE GIVEN: STAT for s/s allergic reaction

DURATION OF PRESCRIPTION: school year

SPECIAL INSTRUCTIONS FOR ADMINISTRATION:

STORAGE REQUIREMENTS OR OTHER CONDITIONS: room temp

IF PRN, FOR WHAT SYMPTOMS: prn for s/s allergic reaction

SHOULD A CHANGE IN ANY OF THE ABOVE INFORMATION OCCUR, A REVISED WRITTEN PHYSICIAN'S STATEMENT MUST BE SUBMITTED.
THIS ORDER IS VALID FOR THE SCHOOL YEAR IN WHICH IT WAS WRITTEN.



OFFICE STAMP NECESSARY HERE ↓

Physician/Practitioner's name:

(Print) _____

Address: _____

City/State/Zip: _____

👉 SIGNED: _____

Telephone #: _____

Date of Completion: _____

👉 Parent/Guardian's Signature* _____ Date _____

Emergency telephone number (daytime) _____

*Parent signature denotes permission to share the above student's medical information with staff on a need-to-know basis.

*Parent signature gives permission to speak to child's physician/practitioner as needed.