Port Jervis School District

High School Health Office – Phone 845-858-3100 Ext 11700 Fax 845-858-3113
Middle School Health Office – Phone 845-858-3100 Ext 12700 Fax 845-858-3226
Anna S Kuhl Health Office – Phone 845-858-3100 Ext 13700/13701 Fax 845-858-3157
Bicentennial Health Office – Phone 845-858-3100 Ext 14700 Fax 845-754-2986

MEDICATION RELEASE FORM

A. TO BE COMPLETED BY PARENT OR GUARDIAN

I request that my child _____ grade _____ receive the medication as prescribed below by our licensed health care provider. The medication is to be furnished and delivered by me in the properly labeled original container from the pharmacy. I understand that the school nurse will administer the medication unless otherwise indicated by the physician.

Signature (parent/guardian) _____
Address _____
Telephone Home _____ Work _____ Date_____

B. TO BE COMPLETED BY THE LICENSED HEALTH PRESCRIBER

I request that my patient, as listed below, receive the following medication:

Name of student_____ Date of birth _____

DIAGNOSIS:_____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Duration of treatment _____
Possible Side Effects and Adverse Reactions (if any): _____
_____
Other Recommendations _____
Prescriber's Signature _____ Date _____
Prescriber's Address _____ Phone _____

PHYSICIAN ATTESTATION

In checking yes below, I attest that the above named student has been instructed in & understands the purpose, appropriate method & frequency of use for the medication ordered. This student is independent in his/her medication use with no assessment or intervention needed by school staff and may self-carry and self-administer the medication ordered.

(MD to check one)

Yes _____ *No*_____