

**Kenmore-Town of Tonawanda UFSD
Dept. of Physical Education/Recreation/
Athletics and Health Services**

**Prescription and Over-the-Counter
Medication Permission Request**

Note to Health Care Provider/Dentist:

Your cooperation is requested to help us care for your patient and to comply with School Health Service Medication Guidelines mandated by New York State.

Please make every effort to recommend administration of medication, particularly controlled substances, outside the school setting. Should you decide that your patient requires administration of medication during school hours, we will comply with your written instructions.

To Whom It May Concern:

The student: _____
(NAME OF STUDENT)

Who attends: _____
(SCHOOL)

Is receiving: _____
(MEDICATION)

For the treatment of: _____
(DISEASE)

For the period of: _____
(DATES)

And should receive: _____ at _____
(MEDICATION) (TIMES)

Possible side effects: _____
(SIDE EFFECTS)

DATE

SIGNATURE OF HEALTH CARE PROVIDER

TELEPHONE

PRINT NAME OF HEALTH CARE PROVIDER

Note to Parent/Guardian:

1. Present this completed form to your child's school nurse with your signature authorizing the approval of your Health Care provider's orders to administer the above medication to your child at school and school related activities during the regular school hours.
2. To ensure the safety of your child and others, **DO NOT SEND THE MEDICATION TO SCHOOL WITH YOUR CHILD. Bring the medication in the original labeled container.**
(This applies to prescription and/or over-the-counter medications.)

I have read my health care provider's instructions and request that the school nurse comply with these orders.

DATE

PARENT/GUARDIAN SIGNATURE