Prescription Medication Order and Permission Form

to be forwarded to
Dover Elementary School
9 Schoolhouse Road
E. Dover, VT 05341
802-464-5386
802-464-0562 (fax)

I hereby give permission to ________________________________ to release information to Dover
(Physician's name)

Elementary School concerning medication(s) prescribed for
_____________________________________.
(name of student)

_____________________________________ _________________________
Signature of Parent/Guardian Date

Medication ________________________________

Directions ________________________________

Beginning Date __________________________

Ending Date __________________________

Reason for Administering: ____

________________________________ ____________________________
Signature of Physician Date

I hereby give my permission for the above named student to take medication as prescribed above at school. All medication is to be administered by an adult.

_____________________________________ _________________________
Signature of Parent/Guardian Date

No medication will be given at school until the school receives this completed form with the prescribed medication in a container appropriately labeled by the pharmacy or physician.

_____________________________________ _________________________
Signature of Principal Date