NISKAYUNA CENTRAL SCHOOLS

SELF-MEDICATION RELEASE FORM

Date:_____

Child's Name: _____

has been instructed in the proper use of the following inhaler/medication (s) :

_____

_____

_____

We (Physician's signature) _____

and (Parent or Guardian signature) _____

request that **(Child's name)** _____ be permitted to carry the inhaler/medication on his/her person or to keep same in his/her locker or P.E. locker, as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate dose, method and frequency of use.

Note: This form must be completed **in addition** to the routine district medication form.

Med 28

Niskayuna Central Schools

TO: **Physician**

FROM: **Niskayuna Schools**

SUBJECT: Medication in School

The following information is required in order for school nurses to administer medication in the schools to students during the day.

Student's Name _____

Diagnosis _____

Medication _____

Dosage _____

Time To Be Given _____

Initiation Date for Medication _____

Ending Date for Medication _____

_____
Physician's Signature

_____
Date

To the Parent:

An adult should deliver the medication to the school nurse. *Medication should be in a properly labeled container with name of child, name of medicine and proper dosage.

I give permission for the above medication to be given to my child, _____

_____, as per Doctor's order.

_____
Parent's Signature

_____
Date