

Hyde Park Elementary School
50 E. Main Street
Hyde Park, VT 05655
Health Office
Phone: 802-521-5409
Fax: 802-888-8591

PRESCRIPTION MEDICATION ORDER AND PERMISSION

Student Name: _____ Date of Birth: _____

Grade: _____ Teacher: _____

Medication Order:

Name of Medication: _____ Strength: _____

Directions: _____

Start Date: _____ End Date: _____

Reason: _____

Healthcare Provider Signature: _____

Parental Permission:

I give permission for the HPES school nurse, or her designee, to mutually exchange information regarding this medication with my child's healthcare provider, _____.

I give permission for the HPES school nurse, or her designee, to administer the above medication to my child during school, as prescribed by the signing physician.

I have read and understand the HPES medication policy, found in the student handbook and on the HPES Health Office website. I agree to adhere to these guidelines.

Parent/Guardian Signature: _____ **Date:** _____

School Nurse Signature: _____ Date Received: _____