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
SELF-ADMINISTRATION

Student Name: ___________________________________ Date of Birth: ___________________

Grade:_____________ Teacher: ____________________________

Medication Order:
Name of Medication: ___________________________________ Strength: __________________

Directions: ____

Start Date: ____________________________ End Date: _______________________________

Reason: ____

This child may carry and **SELF-ADMINISTER** this medication, as prescribed.

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 also give permission for my child to carry and self-administer this medication, as prescribed.

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: ______________