CLARKSTOWN CENTRAL SCHOOL DISTRICT
Health Services

Date_____

We have received your request to have your child receive medication in school.

In order to comply with State Education Law and Clarkstown Board of Education policy, we ask that you sign the following permission form. We also require that your child's physician complete the form below so that we may administer the medication to your child.

This applies to prescription and over-the-counter medication.

TO BE COMPLETED BY PARENT

I wish my child _____ D.O.B: _____ to have the medication prescribed by Dr._____

_____
Parent's Signature

TO BE COMPLETED BY PHYSICIAN

Name_____Date_____

Medication_____

Frequency & Dosage_____

Side Effects To Be Observed, If Any_____

_____

Approx. Duration of Treatment_____

Condition Being Treated_____

_____ _____
Date Signature of Physician

_____
Office Stamp

Form #26