

Please see back for instructions

NORTHERN YORK COUNTY SCHOOL DISTRICT

Medication Order and Request

*This form **must** be completed for any medication brought to school.*

- *Please do **NOT** complete for the school to give generic Tylenol, Advil, or any of the medications listed on the other side of this page.*

Student's Name _____ Grade/Section _____

Diagnosis _____

Medication Name _____ Dosage _____

Route (oral/injection/drops) _____ Time _____

Duration of administration _____

Side effects _____

Other medication student is taking _____

Curtailement of specified school activities (Phys Ed., Driver's Ed., etc.) _____

Physician's Signature _____ **Date** _____ **Phone number** _____

Physician's Name: Please PRINT: _____

I hereby release, indemnify, and hold harmless the Northern York County School District, its employees, and its agents against any claim(s) arising out of the administration of this medication pursuant to this permission form, or related to the benefits or consequences of the prescribed medication. I understand this permission form must be completed by both a physician and the parent/guardian prior to administration of the medication. I agree to inform the School Nurse if any changes occur in this medication.

I give permission for the school nurse to share this information with school staff if necessary. yes no

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

Parent/Guardian's Name: Please PRINT: _____