AMAGANSETT UNION FREE SCHOOL DISTRICT
320 MAIN STREET – P.O. BOX 7062
AMAGANSETT, NY 11930

SCHOOL MEDICATION REQUEST

I hereby request permission for _____ to receive his/her medication as
(Name of Student)
prescribed by_____ on the attached form.
(Physician's name)

This medication is to be administered by the school nurse.

The medication will be handed to the school nurse before school begins and will be kept in the Health Office during the school day.

I will furnish the medication in a properly labeled container, together with a prescription from the physician each time the drug or dosage is changed.

The reason for this request is that our physician states that this medication is needed by my child during school hours.

In the event that my child's albuterol inhaler or epinephrine has not yet been provided to the Health Office or expired, stock medication may be administered if deemed medically necessary by the school nurse.

I accept full responsibility for this request and do hereby release school authorities from all responsibility in the administration of the medication.

Signature_____

Relationship to child_____

Date_____

MJB/2017