EAST RAMAPO CENTRAL SCHOOL DISTRICT

OFFICE OF SPECIAL STUDENT SERVICES
105 South Madison Avenue, Spring Valley, NY 10977
Phone: (845) 577-6040
Fax: (845) 577-6059

SELF MEDICATION RELEASE FORM

Date:_____

Student Name:_____has been instructed in the proper use of the following medication:

Medication	Dosage	Route	Frequency

Health care Provider Signature_____ and

Parent Signature_____ request that the above named student be permitted to carry the medication on his/her person. He/she has been instructed in the medication administration, understands the purpose for the medication, the appropriate method of administration and the frequency of use.

Rev. 6/2008