

TRINITY-PAWLING SCHOOL
700 Route 22
Pawling, New York 12564

HEALTH FORM
HEALTH CENTER
(845) 855-4848 FAX: (845) 855-4851
email: agreene@trinitypawling.org
gbarker@trinitypawling.org

MEDICATION AUTHORIZATION
(To be completed for each prescribed medication)

PARENT PERMISSION (Must be signed for student to receive medication)

I request that my son (print name) _____ receive the medication listed below. I understand that the school nurse, or other designated person in the absence of the school nurse, will administer the medication. Should my son require this medication during a school break, I will notify the school nurse and hereby give permission for him to take the medication with him. I have instructed my son on the dangers of abusing, sharing, or losing this medication. He and I accept full responsibility for it while it is in his possession. ***I will have this medication, and any refills he should receive, sent directly to the school nurse*** in its original container. If your son needs medication to go home for a weekend or vacation, you must notify the Infirmary in advance.

Signature of parent/guardian _____ **Date** _____

PHYSICIAN AUTHORIZATION

Name of student _____

Name of medication _____ Reason for medication _____

Dosage _____ Method of administration _____ Frequency _____

Time of administration _____ Duration of administration _____

Name of medication _____

Name of medication _____ Reason for medication _____

Dosage _____ Method of administration _____ Frequency _____

Time of administration _____ Duration of administration _____

Name of medication _____

Name of medication _____ Reason for medication _____

Dosage _____ Method of administration _____ Frequency _____

Time of administration _____ Duration of administration _____

Other recommendations _____

Name of prescribing physician (please print) _____

Physician's signature _____ **Date** _____

Address _____

Telephone # _____ **Fax #** _____