

Port Jervis Public Schools  
Port Jervis, New York

MEDICATION RELEASE FORM

A. TO BE COMPLETED BY PARENT OR GUARDIAN

I request that my child \_\_\_\_\_ grade \_\_\_\_\_ receive the medication as prescribed below by our licensed health care provider. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse will administer the medication.

Signature (parent/guardian) \_\_\_\_\_

Address \_\_\_\_\_

Telephone Home \_\_\_\_\_ Work \_\_\_\_\_ Date \_\_\_\_\_

B. TO BE COMPLETED BY THE LICENSED HEALTH PRESCRIBER

I request that my patient, as listed below, receive the following medication:

Name of student \_\_\_\_\_ Date of birth \_\_\_\_\_

Diagnosis \_\_\_\_\_

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of treatment \_\_\_\_\_

Possible Side Effects and Adverse Reactions (if any): \_\_\_\_\_

Other Recommendations \_\_\_\_\_

Prescriber's Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_