

THETFORD ACADEMY
THETFORD, VERMONT 05074
SCHOOL HEALTH SERVICES
802-785-4805 X226

PRESCRIPTION MEDICATION PERMISSION FORM

Date _____

I hereby give permission to _____
(physician's name)

to release information to THETFORD ACADEMY concerning medication(s) ‘

prescribed for _____.
(name of student)

SIGNATURE of Parent or Guardian _____

MEDICATION ORDERS:

MEDICATION _____

DIRECTIONS _____

BEGINNING DATE _____ END DATE _____

REASON FOR GIVING _____

PHYSICIAN SIGNATURE _____

PARENTAL PERMISSION FOR DISPENSING MEDICATION AT SCHOOL:

I hereby give my permission for the above named student to take the medication, as prescribed above, at school.

SIGNATURE OF PARENT /GUARDIAN _____

(No medication will be given at school until the health office receives this completed form with the medication in the original container from the pharmacy).

Date rec'd _____ Nurse _____