TROY AREA SCHOOLS – MEDICATION ORDER AND PARENT PERMISSION FOR GIVING MEDICATION IN SCHOOL

STUDENT'S NAME_____DATE OF BIRTH_____

PARENT/GUARDIAN_____DATE_____

SCHOOL_____TEACHER_____

TO THE PHYSICIANS OF CHILDREN REQUIRING MEDICATION DURING THE SCHOOL DAY:

In compliance with the guidelines of Troy Area School District, we are requesting that you complete this form so that the required medication may be administered in school to the named student. Please confer with the parent to arrange medication time intervals to avoid school hours whenever possible. Medication brought to school must be in the original, labeled pharmaceutical container. Thank you.

DIAGNOSIS_____

MEDICATION/DOSAGE/TIME_____

INSTRUCTIONS (Please be specific)_____
_____

POSSIBLE SIDE EFFECTS_____
_____

DURATION OF MEDICATION_____

PHYSICIAN'S SIGNATURE_____

Please fax this form back to the student's school as soon as possible or send with the parent.
FAX NUMBERS:

Troy Jr/Sr High School	570 297-2058
Troy Intermediate School	570-297-5186
WR Croman Primary School	570-297-3260

TO THE PARENT/GUARDIAN: I hereby request that my child, _____, be given the above medication as prescribed by the physician. As his/her parent/guardian, I hereby release the Troy Area School District and all its employees from any and all liability for damages my child may suffer as a result of this request.

PARENT SIGNATURE_____DATE_____