THETFORD ACADEMY
ACADEMY ROAD
P.O. BOX 190
THETFORD, VERMONT 05074-0190
SCHOOL HEALTH SERVICES
802-785-4805 EXT.

PRESCRIPTION MEDICATION ORDER AND PERMISSION FORM
TO BE FORWARDED TO THE SCHOOL NURSE

DATE _____

I hereby give my 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 or Guardian_____
(No medication will be given at school until the school receives this completed form with the prescribed medication in a container appropriately labeled by the pharmacy and/or physician.) Date received_____Nurse_____