

**CLARKSTOWN CENTRAL SCHOOL DISTRICT**  
**Health Services**

Date \_\_\_\_\_

Dear \_\_\_\_\_,

We have received your request to have your child \_\_\_\_\_  
receive medication in school.

We wish to cooperate with you in every way possible to improve and maintain your child's health. It is for the best interests of all that the school nurse dispense medication during school hours.

In order to comply with State Education Law and Clarkstown Board of Education policy, we ask that you sign the following permission form. We also require that \_\_\_\_\_'s physician complete the form designed for this use so that we may properly care for your child.

Very truly yours,

\_\_\_\_\_  
School Nurse

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**TO BE COMPLETED BY PARENT**

I wish my child \_\_\_\_\_ to have the medication prescribed by

Dr. \_\_\_\_\_ on \_\_\_\_\_.

\_\_\_\_\_  
Parent's Signature

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**TO BE COMPLETED BY PHYSICIAN**

Name \_\_\_\_\_ Date \_\_\_\_\_

Medication \_\_\_\_\_

Frequency & Dosage \_\_\_\_\_

Side Effects To Be Observed, If Any \_\_\_\_\_

Approx. Duration of Treatment \_\_\_\_\_

Condition Being Treated \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Physician