

Medication Order Form
for
Nyack Public School District

Student Name: _____, Date of Birth: _____

I, _____ give permission for the school nurse to administer medication as per the physician's orders below. I also give permission for the nurse to contact my child's physician concerning any medication issues that may arise.

Parent/Guardian - Print Name

Parent/Guardian - Signature

Date

.....
PHYSICIAN ORDERS - Please write prescription(s) below:

Physician Signature: _____

Date: _____

MD Stamp required: