Farmington River Regional School District
Otis & Sandisfield
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Medication Dispensing – In-School Permit

To be completed by a parent or guardian:

I authorize the School Nurse to see that my child ___________________________________ receives the medication prescribed by Dr. ________________________________ for the school year from ___________ to _____________.

This medication is to be in a labeled container with the name of the medication, the amount to be given, time to be given, the name of the student and the prescribing physician's name on the label.

Signature of parent/guardian: ____

To be completed by the physician:

Name of medication: ____

Dosage of medication: ____

Time of Administration: ____

Special instructions: ____

Signature: ____
Physician, Dentist, Nurse Practitioner, etc.

Date: ____