NORTH KINGSTOWN SCHOOL DISTRICT
NORTH KINGSTOWN, RI 02852
WWW.NKSD.NET

EDUCATE
INSPIRE
CHALLENGE

Fishing Cove
Clinic Phone # 268-6583

Fishing Cove
Fax 268-6590

NI [redacted]

MEDICAL PERMISSION SLIP

Date _____

Student _____ **Grade** _____ **HR** _____

Name of Medication* _____ **Dosage*** _____

Diagnosis* _____ **Time to be given*** _____

Daily* _____ **As Needed*** _____ **(check one) Side Effects*** _____

Self Carry/Self Administration? Yes No (N/A if controlled substance)

Other Information _____

Subject to the following conditions:

1. Any controlled substance will be brought to the school by a responsible **ADULT** in a pharmacy labeled container.
2. Any other medication will be brought to school in the original labeled container.
3. Medication will be kept in the clinic unless otherwise indicated by School Nurse Teacher (as in the case of self administration).
4. As parent/guardian, I give permission for the School Nurse Teacher to discuss the above information with my child's family health care provider.

I give permission for this student to receive the above medication at school according to school policy and understand school regulations regarding its administration.

Medication must be taken on a field trip: Yes____ No ___

_____ _____

Parent/Guardian_____ Relationship to Student _____

_____ _____

Physician/Family Health Care Provider Date

*** Items to be completed by physician/family health care provider**