North Kingstown School Department
Davisville Academy
55 East Court
North Kingstown, RI 02852
Phone; 401-541-6352
Fax: 401-398-7114
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Educate
Inspire
Challenge

Date_____

MEDICATION PERMISSION SLIP

Student_____Grade_____HR_____

Name of Medication*_____Dosage*_____

Diagnosis*_____Time to be given_____

Daily*_____As Needed_____(Check one) Side Effects*_____

Self Carry/Self Administer? Yes___No___(N/A if controlled substance)

Other information_____

Subject to the following conditions:

1. Any controlled substance will be brought to 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 (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 physician.

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

Medication must be taken on a field trip: Yes___No___

_____ _____
Parent/Guardian Relationship to Student

_____ _____
Physician Signature Date

* Items to be completed by physician.