ROCK POINT SCHOOL
ONE ROCK POINT ROAD
BURLINGTON, VERMONT 05408

PRESCRIPTION MEDICATION ORDER AND PERMISSION FORM
TO BE FORWARDED TO THE SCHOOL NURSE

Date _____

I hearby give my permission to _____to release
Physician's Name

information to _____ concerning medication(s)
School Name

prescribed for _____.
Name of Student

Signature of Parent or Guardian _____
****

Medication _____

Directions _____

Start date _____ Stop date _____

Reason for giving _____

Signature of Prescriber _____
****

I hereby give permission for the above named student to take the medication as prescribed above at school.

Signature of parent or guardian _____

No medication will be given at school until the school receives this completed form with the prescribed medication in a container, appropriately labeled by the pharmacy or prescribing clinician.

PHONE 802 863-1104
FAX 863-6628
www.rockpointschool.org