

WATERFORD – HALFMOON UNION FREE SCHOOL DISTRICT

125 MIDDLETOWN ROAD
WATERFORD NY 12188

Physician's Order for Medication to be Administered by School Personnel

_____ has been under my care for
(Student Name)

He/she is able to return to school but must take:

_____ as follows

_____ during school hours.

Date

Physician's Signature

Parent's Request for Administration of Medication

I/we hereby request that the medication ordered by our physician as indicated above be administered as ordered to our child.

Child's Name

Grade

Parent's Signature

Parent's Signature

Date