Sharon Elementary School Health Office
75 Vermont Rte. 132
Sharon, VT 05065
Ph: (802) 763-7425 Fax: (802) 763-2056

Prescription Medication Order and Permission Form

Please complete one form per medication.
Must be renewed annually,

Student's Name_______________________ _____ Date of Birth _______________

Grade ___________

To be completed by the physician or authorized prescriber

Medication_______________ ___________________ Dosage _______________
Reason for giving _________________ _______________________
Time(s) to be administered __________________________
Start date ________________________ End date _________________________

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Self-administration (for Asthma Inhalers and Epi-pens)
(Student's name)_________________ is knowledgeable about this medication and is able to self-administer it. Yes_____ No_____

Provider signature________________________________ Date ___________
Provider's name printed _______________________ Phone ______________
Fax _________________ email ________________________________

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To be completed by the parent/guardian
I give permission for (name of child) ________________ to receive the above medication at school according to the school medication policy. I also give permission for my provider to communicate with my school nurse re: this medication and my child's response to it. *This information will be held confidential except on an educationally as needed basis.*

Parent signature_________________________ Date ____________________

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Received by the School Nurse
Signature______________________________Date _______________________