Marion Cross School

22 Church Street
Norwich, Vermont 05055
PH: 802.649.1703

Shawn Gonyaw, *Principal*

Prescription Medication Order and Permission Form

Name of Student______________________**DOB:**______________________
Teacher________________ **Grade:**______

Medication:____

Directions: ____

Beginning Date: ________________________ **Last Dose:**____________________________

Reason for Giving: ____

I hereby give my permission to
(prescribing licensed provider)________________________________
to release information to Marion Cross School, Norwich, VT.
concerning medication(s) prescribed for
(name of student)________________________________.

Parent /Guardian Signature:______________________________
Date:_____________________

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

Parent/Guardian Signature:_______________________________
Date:__________________

Health Care Provider Signature:_____________________________
Printed Name: _________________________**Date:**______________

Date Received ___________ Signature of School Nurse _________________________

** No medication will be given at school until the school receives this completed form with the prescribed medication.

**The medication must be in the original container appropriately labeled by the pharmacy or physician.

**All medicine brought into the school must be kept in the health office during school hours.