CITY SCHOOL DISTRICT OF PEEKSKILL
Peekskill Middle School
212 Ringgold Street
Peekskill, NY 10566
(914) 737-4542 Fax (914) 737-3253

A. To be completed by PARENT or GUARDIAN:

I request that my child _____ (Date of Birth)_____

receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy.*

Signature (Parent or Guardian)_____

Telephone: Home _____ Work _____ Date_____

B. To be completed by the Private Healthcare Provider:

I request that my patient, as listed below, receive the following medication:

Name of Student: _____ DOB_____

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Possible side Effects and Adverse Reactions (if any):

Healthcare Provider's Signature _____ Date:_____

Address: _____ Phone:_____

***Medication must be in original pharmacy labeled container with specific orders and name of medication.**
***Medication and refills must be brought to school by parent, guardian or responsible adult.**

This medication order is valid for the current school year and summer school as needed.

At the Peak of Excellence!
Peekskill Schools

PEEKSKILL CITY SCHOOL DISTRICT

Administration Center, 1031 Elm Street • Peekskill, NY 10566-3499
(914) 737-3300

SELF-MEDICATION RELEASE FORM

Date: _____

Student's Name: _____

has been instructed in the proper use of the following medication procedures:_____
_____
_____

We (Physician's Name) _____

And (Parent or Guardian's Name) _____

request that (Student's Name)_____be permitted to carry the medication on his/her person or to keep same in his/her locker or P.E. locker, as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of use.

Note: This form must be completed ***in addition*** to the routine district medication form for those students who request permission to carry their own medication on campus or keep this medication a locker or P.E. locker