WALLENPAUPACK AREA SCHOOL DISTRICT

2552 Route 6
Hawley, PA 18428-9045
(570) 226-4557 ext. 3000
Fax: (570) 226-0638

SHORT TERM PARENTAL MEDICATION PERMISSION SLIP

(Not to exceed two weeks, unless accompanied by a signed doctor's note)

To: School Nurse

I wish to make known to the Wallenpaupack Area School District that my child,

_____, is taking medication prescribed by:

Parent: _____ Physician: _____

Name of medication: _____

Amount to be taken: _____ Time of day to be taken: _____am _____pm

Expected duration of treatment:

Period from: _____ to _____
date date

I do hereby discharge, and hold harmless the Wallenpaupack Area School District, its agents and employees, from any and all liability and claim whatsoever, for the administration of the above medication to my child.

Signature: _____
Parent/Guardian

Date: _____ School: _____

Remarks: