WALLENPAUPACK AREA SCHOOL DISTRICT

HC 6, Box 6075
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: