



Medication Release Form

I hereby give permission for my child _____
student's name

(DOB: _____) to receive his/her medication as per physician's order while he/she is enrolled in the Northshore Education Consortium.

The medication, dose and time schedule is as follows:

MEDICATION	DOSAGE	TIME SCHEDULE	HOW GIVEN
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Skilled Nursing Treatment/Procedure/Intervention(s)*

Please write in specific nursing orders for suctioning, cpt, enteral tube replacement/feeds, capillary blood sugar testing, VNS activation, tracheotomy replacement/care, O2 sats, please indicate and prns, other: feeding modifications (i.e. NPO, taste only thickened liquids; include specific consistency, i.e. nectar/honey).

* Family is responsible to supply student specific supplies and durable medical equipment.

RN may:

Physician's Signature

Physician's Name/Address (Printed)

Physician's Telephone Number

Date

PARENTAL PERMISSION:

Parent/Guardian Signature

Parent/Guardian Name (Printed)

Date

If the Consortium has any questions they can contact my child's physician or myself.