



(Student Name – Last, First)

(Teacher)

(Grade)

The mission of the Three Village Central School District, in concert with its families and community, is to provide an educational environment which will enable each student to achieve a high level of academic proficiency and to become a well-rounded individual who is an involved, responsible citizen.

**THREE VILLAGE
CENTRAL SCHOOL DISTRICT**

Parent and Physician’s Authorization for Administration of Medication in School

A. To be completed by the parent or guardian:

I request that my child _____ grade _____ receive the medication as prescribed below by our physician. The medication is to be furnished by me in properly labeled original container from the pharmacy. I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication.

Signature (Parent or Guardian): _____

Address: _____

Telephone: Home: _____ Work: _____ Cell: _____ Date: _____

B. To be completed by the physician:

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

Name of Student: _____ Date of Birth: _____

Diagnosis: _____

Name of Medication: _____

Prescribed Dosage, Frequency & Route of Administration: _____

Time to be taken during school hours: _____

Duration of Treatment: _____

Possible Side Effects and Adverse Reactions (if any): _____

Other Recommendation: _____

Name of Physician (please print): _____

If authorization is signed by a Physician Assistant or Nurse Practitioner, the name of the supervising physician must be indicated.)

Signature: _____ Date: _____

Address: _____ Phone: _____

Neal Lederer, **Interim Superintendent of Schools**
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