



\_\_\_\_\_  
(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: \_\_\_\_\_

Donald F. Webster, **Interim Superintendent of Schools**  
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**Interim Asst. Superintendent:** B. Allen Mannella, Human Resources  
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