

THREE VILLAGE CENTRAL SCHOOL DISTRICT

PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

Authorization for Administration of Medication

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 _____ 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 the school hours: _____

Duration of Treatment: _____

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

Other Recommendations: _____

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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: _____