

PARENT & PRESCRIBER'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 licensed health care prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse will administer the medication or an adult will supervise my child taking his/her own medication.:

Signature (Parent or Guardian): _____

Address: _____

Telephone: Home _____ Work _____ Date: _____

B. To be completed by the licensed health care prescriber:

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 and 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 Licensed Prescriber and Title (please print): _____

Prescriber's
Signature: _____ Date: _____

Address: _____ Phone: _____

North Salem Middle/High School Nurse

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