SUFFERN CENTRAL SCHOOL DISTRICT

Hillburn, New York

PARENT AND 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 provider. 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 faculty member, in the nurse's absence.

Parent/Guardian
Signature:_____Date:_____

Address:_____

Telephone: Home_____ Work_____

Cell _____

B. To be completed by the Health Care Provider:

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 Recommendations: _____
Name of Licensed Provider and Title (please print): _____
_____
Provider's Signature:_____ Date: _____
Address: _____ Phone: _____