SOUTH HUNTINGTON UNION FREE SCHOOL DISTRICT
Student Services

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

A. To be completed by 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, or other assigned person will administer the medication.

Signature (parent or guardian) ______________________________

Address: ______________________________

Telephone: (Home) ______________ (Work) ______________ Date: ________

B. To be completed by the licensed 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 Prescriber & Title (please print): ______________

Prescriber's Signature: ______________________ Date: ________

Address: ______________________________ Phone: ________

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