AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

A) To be completed & signed by the parent or guardian, and signed by the Physician.

I give permission for the administration of the following medications/treatments for my Child_____________________, Grade ______, Teacher _____________. I understand that I will need to supply the medication/treatments in a properly labeled original container from the pharmacy.

Signature (Parent/Guardian): ____ Date: __________

Please initial for permission:
_______ Insect Repellant
_______ Sunscreen
_______ Cough Drops
_______ Hydrocortisone cream
_______ Bacitracin
_______ Acetaminophen ____________Dosage ______________________________Frequency

Signature of Physician: ____ Date:__________

Due to NY State Department of Education's revised recommendations for the administration of medication in schools, individual doctor's orders will be required for any medicine including, Tylenol. Medication will be administered only with parental permission and the doctor's order.

B) To be completed by the Physician:

I request that my patient, as listed below, receive the following medication:

Student Name: ____________________________________ Date of Birth: ________________

Diagnosis: ____

Name of Medications: ____

Prescribed Dosage-Frequency and Route of Administration:___________________________

Time to be taken during school hours:____

Duration:____

Possible side effects and adverse reactions, if any:___________________________________

Other Recommendations: ____

Name of licensed prescriber and title (Please print)______________________________

Prescriber's Signature:______________________________Date:______________________
Address: _______________________________________ Telephone #: _________________