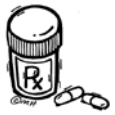

PARENT AND HEALTHCARE PROVIDER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

A. To be completed by the Parent or Guardian:

I request that my child_____(Date of birth:_____) receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy*.

Signature(Parent or Guardian): _____

Telephone: Home_____Work_____Date _____

B. To be completed by the Private Healthcare Provider:

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

Name of Student_____DOB _____

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Possible Side Effects and Adverse Reactions (if any):

Healthcare Provider's Signature_____Date:_____

Address:_____Phone: _____

**Medication must be in original pharmacy labeled container with specific orders and name of medication.*
**Medication and refills must be brought to school by parent, guardian or responsible adult.*

This medication order is valid for the current school year and summer school as needed.
SCHOOL NURSES OFFICE FAX
Jr./Sr. High School: (518) 827-5162
Elementary School: (518) 827-3289