School Health Services

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): _____ Date _____

Telephone: Home _____ Work _____

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 the 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