School Health Services

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

A. To be completed by t	the Parent or Guard	dian:	
	below by our physician.	(Date of birth: The medication is to be furnish	
Signature (Parent or Guardian):			_ Date
Telephone: Home		Work	
B. To be completed by to I request that my patient, as I was Name of Student	isted below, receive the		DOB
MEDICATION	DOSAGE	FREQUENCY/ TIME TO BE TAKEN	ROUTE OF ADMINISTRATION
Possible Side Effects and Ad	verse Reactions (if any)	:	
Healthcare Provider's Signatu	ure		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