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

Authorization for Administration of Medication

A. **To be completed by the parent or guardian:**

Child's Date of Birth: _____

I request that my child _____ grade _____ receive the medications prescribed below by our licensed health care prescriber. 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 designated person in the case of the absence of the school nurse, will administer the medication:

Signature (Parent or Guardian) _____

Address _____

Telephone (Home) _____ Work _____ Cell _____

B. **To be completed by the licensed health care prescriber:**

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): _____

_____

Name of Licensed Prescriber: _____ Title: _____

Prescribers Address: _____

_____

Doctor's Signature: _____Date: _____