West Irondequoit Central School District

Parent and Prescriber's Authorization for Administration of Medication in School

Student Name:_____ School:_____

Date of Birth:_____ Grade:_____

A. To be completed by the parent or guardian:

I request that my child receive the medication as prescribed below by our licensed health care provider. 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 assigned person will administer the medication. I understand that this request must be renewed annually or whenever there is a change in the original prescription.

Signature (Parent or Guardian):_____

Address: _____

Phone - Home:_____ Work _____ Date:_____

B. To be completed by the licensed health care provider:

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 / Adverse Reactions:_____

Other Recommendations: _____

_____

Name of Licensed Prescriber (please print):_____ Title:_____

Address:_____ Phone:_____

Licensed Prescriber's Signature:_____ Date:_____