VESTAL CENTRAL SCHOOLS

VESTAL NEW YORK 13850

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION

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

PRESCRIPTION AND NONPRESCRIPTION

A. To be completed by the parent or guardian:

I request that my child_____ grade _____ receive the medication as 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 (____) _____ Date: _____

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 _____

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) _____

_____

Other Recommendations _____

_____

Name of Licensed Prescriber and Title (please print)_____

♦ **Prescriber's Signature** _____

Address _____ **Phone (____)**_____