

Sachem High School – East

177 Granny Road

Farmingville, NY 11738

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:

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: _____ 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 Reaction (if any): _____

Other Recommendations: _____

Name of Licensed Prescriber and Title (Please Print): _____

Prescriber's

Signature: _____ Date: _____

Address: _____ Phone: _____