BRIARCLIFF UNION FREE SCHOOL DISTRICT HEALTH SERVICES

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 ____, in 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.

Parent Signature: ____

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: ____

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): ____

Address: ____

Telephone: ____

Prescriber’s Signature: ____

Date: ____