Academic Year _____

BRIARCLIFF UNION FREE SCHOOL DISTRICT
HEALTH SERVICES
444 Pleasantville Road
Briarcliff Manor, NY 10510

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)

_____

Prescriber's Signature: _____

Address:_____

Telephone:_____

Date:_____