

# Willsboro Central School Authorization for the Administration of Medication in School

## 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 absence of the school nurse, will administer the medication.

Signature (Parent/Guardian): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_

## 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 reactions (if any): \_\_\_\_\_

Other recommendations: \_\_\_\_\_

\_\_\_\_\_

Name and title of licensed prescriber (please print): \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_