RYE NECK UNION FREE SCHOOL DISTRICT
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: Child's Date of Birth _______
I request that my child ________________________ grade _________ receive the Medications 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 absences of the school nurse, will administer the medication:

Signature (Parent or Guardian) _________________________________

Address ____

Telephone (Home) _______________ Work ______________________

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: ___________

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Time to be taken during school hours _____________________________

Duration of treatment ____
Possible side effects and adverse reactions (if any) ___________________

Name of Licensed Prescriber and Title (please) _____________________
Date _____________________Prescribers Name and Address _________

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Doctor's signature_______________________Dated____/____/____