MALVERNE UFSD
MALVERNE, NEW YORK 11565

Parent and Prescriber Authorization for Administration of Medication in School

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): _____Date: _____

Address: _____

Telephone: Home: _____Work: _____Cell: _____

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 reactions (if any): _____

_____

Other recommendations: _____

_____

Name of licensed prescriber and title (please print): _____

Signature: _____Date: _____

Address: _____Phone: _____

C. SELF-MEDICATION REQUEST:

Child' name: _____

has been instructed in the proper use of the following medication procedures: _____

_____

We (**Physician's Signature**): _____Date: _____

and (**Parent or Guardian's Signature**): _____Date: _____

request that this student be permitted to carry the medication on his/her person or to keep same in his/her locker or P.E. locker, as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of use.