OFFICE OF STUDENT HEALTH SERVICES
PATCHOGUE-MEDFORD SCHOOLS
181 Buffalo Avenue
Medford, NY 11763
Telephone (631) 687-6420

PARENT AND PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND ON SCHOOL-SPONSORED FIELD TRIPS

Authorization for Administration of Medication

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 case of the absence of the school nurse, will supervise the administration of the medication in school and on school sponsored field trips as directed.

Signature of Parent/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(s) to be taken during school hours _____ Duration of Treatment _____

Possible side effects and adverse reactions (if any) _____

_____

Other recommendations: _____

_____

Prescriber's signature _____ Date _____

Address _____ Telephone _____

Affix Stamp Here:

MEDICATION RECORD

STUDENT NAME _____ **GRADE** _____ **ROOM** _____

NAME OF MEDICATION **DOSE** **GIVEN AT**

September	October	November	December	January	February	March	April	May	June