SMITHTOWN CENTRAL SCHOOL DISTRICT

26 NEW YORK AVENUE, UNIT 1, SMITHTOWN, NEW YORK 11787-3435

PHYSICIAN'S ORDER FOR GIVING MEDICATION IN SCHOOL

PUPIL'S NAME _____ ADDRESS _____

PARENT/GUARDIAN NAME _____

TO PHYSICIANS AND PARENTS OF CHILDREN REQUIRING MEDICATION IN SCHOOL:

In compliance with the rules and regulations of the New York State Education Department, you are requested to complete this form so the required medication may be administered in school to your child.

NAME OF DRUG _____

GENERIC NAME OF DRUG, IF POSSIBLE _____

DOSAGE AND FREQUENCY _____

EXPECTED EFFECT _____

POSSIBLE SIDE EFFECTS _____

DIAGNOSIS _____

TIME DURATION OF ORDER _____ DAYS _____ MONTHS _____

DATE ORDER IS EFFECTIVE _____

_____
Physician's Signature/Date

_____
Physician's Telephone Number

Physician's Stamp

PARENT REQUEST TO SCHOOL TO GIVE MEDICATION

I, hereby request that my child, _____ be given the medication as (FULL NAME) prescribed by the physician. We, the parent/guardian, authorized the school to assist our child in taking medication and agree that we will not hold liable any member of the school staff or an individual of official capacity who is directed by us (the parent/guardians) and the school administrator to assist our child in taking said medication. The parent/guardian will note expiration date of medication and will supply new medication when if it should expire during the school year.

_____
Parent/Guardian Signature

Received by_____ Quantity_____ Expiration _____