



AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS BY SCHOOL PERSONNEL

If a Preschool chooses to administer medications, the New York State Law and Regulations require a physician's or dentist's written order and parent or guardian's authorization for a nurse, the director or teacher to administer medications. Medications must be in pharmacy prepared containers and labeled with name of child, name of drug, strength, dosage, frequency, physician's or dentist's name and date of original prescription. Over the counter medication must be in the original container and labeled with the child's name.

PHYSICIAN OR DENTIST ORDER

Name of Child _____ Date of Birth _____
Address _____

Condition for which drug is being administered during school hours _____

MEDICATION:

Name, dose and method of administration _____

Time of administration _____

Medication shall be administered _____ to _____
(Date) (Date)

Relevant side effects to be observed, if any _____

If there are side effects, plan for management _____

Is this a controlled drug? _____

Allergies to food or drugs? If yes, list _____

Physician's/Dentist's Name _____

Address _____

Physician's or Dentist's Signature _____ Date: _____

AUTHORIZATION BY PARENT/GUARDIAN FOR THE ADMINISTRATION OF THE ABOVE MEDICATION:

To School Nurse, Director or Teacher:

I hereby request that the above medication, ordered by the physician/dentist for my child, _____, be administered by the nurse, director or teacher. I understand that I must supply the school with the prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist. Over the counter medication shall be in the original container labeled by the parent with the child's name. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order.

Parent/Guardian Name _____ Relationship _____

Signature _____ Date _____

Address _____ Telephone _____

PLEASE NOTE YOUR CHILD MAY NOT REMAIN AT SCHOOL UNLESS/UNTIL THESE FORMS ARE COMPLETED.



Drug Name _____
 Physician's Name _____

Child's Name _____
 Prescription # _____
 Pharmacy _____

Dosage Ordered & Method of Administration:

Date	Time	Dose	Signature of Person Administering Medication	Comments

BEFORE ANY MEDICATION IS ADMINISTERED FOR THE FIRST TIME, THE FOLLOWING ITEMS MUST BE IN PLACE.

- The authorization form is completed
- The medication is in a safety-cap container
- The original prescription label is on the medication container
- The name of the child is on the container
- The date on the prescription is current (within the month for antibiotics & within the expiration date for medications, which are so labeled)

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