BROADALBIN-PERTH CENTRAL SCHOOL DISTRICT

Authorization for Administration of Medication

SECTION 1 — To be completed by parent or guardian (please print)

I request that my child, _____, born on (DOB) _____, receive the medication as prescribed below by our physician. 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, including during field trips.

Parent/Guardian Signature: _____ Date: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

SECTION 2 — To be completed by the physician

I request that my patient, as listed below, receive the following medication:

Child's Name: _____ Date of Birth: _____

Diagnosis: _____

Medication	Dosage	Frequency/Time to be Taken	Route of Administration

Duration of Treatment: _____

Possible Side Effects or Adverse Reactions (if any): _____

* Medication must be in original pharmacy labeled container with specific orders and name of medication. Medication and refills must be brought to school by parent, guardian or responsible adult.

By signing below, we indicate that the physician has reviewed the child's medication plan with the parent(s)/guardian(s):

Physician's Signature: _____ Date: _____

Address: _____ Phone: _____

Parent/Guardian Signature: _____ Date: _____