HEWLETT- WOODMERE PUBLIC SCHOOLS

Parent and Prescriber's Authorization for Administration of Medication in School

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 the case of the absence of the school nurse, will administer the medication. _____

Signature (Parent or Guardian):_____

Address: _____

Telephone: Home_____ Cell _____ Work _____ Date _____

A. 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 or treatment: _____

Possible Side Effects and adverse reactions (if any):_____

_____

Other recommendations: _____

_____

Name of licensed prescriber and Title: _____

Prescriber's Signature: _____ Date: _____

Address: _____ Phone: _____