Chappaqua Central School District
Post Office 21
Chappaqua, New York 10514

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 container from the pharmacy. I understand that the school nurse or her designee will administer the medication.

Signature (Parent or Guardian):_____

Address:_____

Telephone: Home_____work_____Date:_____

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:_____Sex:_____Date of Birth:_____
Diagnosis:_____

Name of Medication:_____

Prescribed Dosage, Frequency and Route of Administration:

Time to be taken during School Hours: _____

Duration of Treatment:

_____

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

Other Recommendations: _____

Name of Licensed Prescriber (please print):_____

Prescriber's Signature: _____ Date:_____

Address: _____ Phone: _____