GREAT NECK PUBLIC SCHOOLS
Health Services
Physician's Order / Parent Authorization for Administration of Medication

SCHOOL _____

DATE _____ GRADE _____

PHYSICIAN'S ORDER

TO BE COMPLETED BY PHYSICIAN:

PLEASE ADMINISTER TO MY PATIENT: _____

THE FOLLOWING MEDICATION AS INDICATED:

MEDICATION _____

DIAGNOSIS _____

REASON FOR ADMINISTRATION _____

DOSAGE _____

TIME _____

SIDE EFFECTS, IF ANY _____

_____
Physician's Signature & Stamp

_____
Date

PARENT AUTHORIZATION

TO BE COMPLETED BY THE PARENT OR GUARDIAN:

I request that my child, _____, grade_____, receive the medication (Prescription or Over the Counter) prescribed 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 assigned person will administer the medication.

_____
Parent or Guardian Signature

_____
Date