



# Manhasset Public Schools

Health Offices

## PARENT AND PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

### **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. Furthermore, I understand it is my responsibility to immediately notify the Health Office of any change in the type, dosage, or frequency of administering the medication.

Signature (Parent or Guardian): \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_

### **B. TO BE COMPLETED BY LICENSED HEALTH CARE PRESCRIBER:**

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

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD-9 code \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Prescribed Dosage, Frequency, and Route of Administration: \_\_\_\_\_

\_\_\_\_\_

Time to be taken during school hours: \_\_\_\_\_

In the event of a field trip, can this dose be held? Yes \_\_\_ No \_\_\_

Duration of Treatment: \_\_\_\_\_

Possible Side Effects and Adverse Reactions (if any): \_\_\_\_\_

Other Recommendations: \_\_\_\_\_

Name of Licensed Prescriber and Title (Please Print): \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Stamp \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_