Manhasset Public Schools

Health Offices

Administration of Asthma Medication in School
Parent and Physician Authorization

A. TO BE COMPLETED BY THE PARENT OR GUARDIAN:

I request that my child _____, Grade___, receive the medication prescribed below by a licensed health care prescriber. The medication is to be furnished by me in a properly labeled, original container from the pharmacy. I understand that the school nurse, or other designated person, in the absence of the school nurse, will administer the medication. Furthermore, I understand that it is my responsibility to notify the school nurse immediately of any changes in the type, dosage or frequency of 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 Asthma Medication:

Name: _____ Date of Birth: _____

Diagnosis: _____ICD-9 code_____

Prescription directions: _____

Time to be taken:_____ Duration of Treatment:_____

Side Effects/Adverse Reactions:_____

C. SELF-MEDICATION AUTHORIZATION:

The above named patient has been instructed in the proper use of the following medication procedures:

_____

It is requested that _____ be permitted to carry the medication on his/her person or to keep the same in his/her locker, as he/she is considered to be responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency for use.

Parent/Guardian Signature: _____

Physician Signature: _____

Name & Title of Prescriber (Please print): _____ Stamp _____

Signature: _____Date: _____

Address: _____ Phone #: _____