ORISKANY CENTRAL SCHOOL
Parent and Physician'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 the School Nurse at **N.A. Walbran Elementary School** administer Medications as prescribed below by our physician for my child_____, during school hours. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse will administer the medication or an adult will supervise my child taking his/her own medication

Signature (Parent or Guardian):_____

Address: _____

Telephone: Home_____Work_____Date_____

B. To be completed by the licensed health care prescriber:

Name of student _____Date of Birth_____

Diagnosis: _____

Name of Medication_____

Dosage and frequency and Route of Administration:_____

_____

Time to be Taken During School Hours:_____

Beginning_____ To_____
Date Date

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

_____

Other Recommendation:_____

Name of Licensed Prescriber and Title (please Print)_____

Prescriber's Signature: _____Date_____

Address: _____Phone:_____