

**CHESTER UNION FREE SCHOOL DISTRICT**  
**ELEMENTARY SCHOOL**  
845-469-2231 ext 2209  
Fax: 845-469-2794

**MIDDLE/HIGH SCHOOL**  
845-469-2231 ext 3315  
Fax: 845-469-6634

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

**A. To be completed by the parent/guardian:**

I request that my child \_\_\_\_\_ grade \_\_\_\_\_  
Receive the medication as prescribed below by our licensed health care provider. 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 case of the absence of the school nurse, will administer the medication.

Signature (Parent/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: \_\_\_\_\_ Date: \_\_\_\_\_

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 and Title (please print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

**C. Self Medication Release :**

My student, \_\_\_\_\_, has been instructed in the proper use of the  
following emergency medication procedures: \_\_\_\_\_

We (Physician's signature) \_\_\_\_\_ and

(Parent/Guardian's signature) \_\_\_\_\_

request that my student be permitted to carry the emergency medication on his/her person or to keep same  
in his/her locker or P.E. locker, as we consider him/her responsible. He/she has been instructed in and  
understands the purpose and appropriate method and frequency or use.

Original: Nurse's Office