



Manhasset Public Schools

Health Office

SHELTER ROCK

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 by 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. I give my permission to share this information on a need to know basis.

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: _____

Shelter Rock School Health Office: 27A Shelter Rock Road, Manhasset, NY 11030

Attn: Teresa Muller, RN / Caitlin, Abdo, RN, BSN

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