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:_____

Diagosis_____ICD-9 code_____

Epinephrine:_____

Dose to be given/Route of Administration:_____

Antihistamine:_____

Dose to be given/Route of Administration:_____

Other (e.g., inhaler-bronchodilator if asthmatic):_____

Dose to be given/Route of Administration:_____

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

State which of these medications this child can self-administer:_____

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
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