

**PLAINVIEW – OLD BETHPAGE CENTRAL SCHOOL DISTRICT**

**PARENT AND HEALTHCARE PROVIDER’S AUTHORIZATION FOR  
ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES**

**A. To be completed by the Parent or Guardian**

I request that my child \_\_\_\_\_ DOB: \_\_\_\_\_ receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy\*. I understand that the school nurse or her designee in the event of her absence will assist the child.

Signature (Parent or Guardian): \_\_\_\_\_ Date: \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**B. To be completed by the Private Healthcare Provider:**

I request that my patient, as listed below, receive the following medication:

Name of student: \_\_\_\_\_ DOB: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

MEDICATION	DOSAGE	FREQUENCY/ TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Possible Side Effects and Adverse Reactions (if any): \_\_\_\_\_

Prescriber’s Signature & Stamp: \_\_\_\_\_ Date: \_\_\_\_\_

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

*\* Medication must be in original pharmacy labeled container with specific orders and name of medication.  
\* Medication and refills must be brought to school by parent, guardian or responsible adult.*

This medication order is valid for the current school year and summer school as needed.