



EARLY CHILDHOOD CENTER /LOWER SCHOOL Paula Edell, R.N.
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AUTHORIZATION FOR DISPENSING MEDICATION

Please use one form for each prescription that is to be administered in school

A. TO BE COMPLETED BY HEALTH CARE PROVIDER:

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

Child's Name: _____ Grade: _____ Date of Birth: _____

Name of Medication: _____ Diagnosis: _____

Dosage and Route of Administration: _____

Times(s) to be Given: _____ Duration: _____

Possible Side Effects and Adverse Reactions: _____

Other Recommendations: _____

Please choose one option:

- ☐ Student may self-carry and self-administer the medication.
- ☐ Student may self-administer medication under supervision of nurse or school personnel.
- ☐ Nurse must administer medication to student. (This option required for ALL ECC/Lower School students)

Health Care Provider's name (printed or typed)

Phone

Signature

Date

B. TO BE COMPLETED BY PARENT:

I request that my child _____ in grade _____ receive the medication as prescribed above by our licensed health care provider. The medication is to be furnished by me in the properly labeled original container from the pharmacy.

Please choose one option:

- ☐ My child may self-carry and self-administer the medication.
- ☐ My child may self-administer medication under supervision of nurse or school personnel.
- ☐ Nurse must administer medication to my child. (This option required for ALL ECC/Lower School students)

Signature of Parent/Guardian

Phone

Date

No medication will be accepted or administered by school personnel unless it is accompanied by a completed copy of this form. All medications to be furnished by parent/guardian in an appropriate container with pharmacy and/or manufacturer's label.