Policy 5420E3

Manhasset Public Schools

Health Offices

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 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.

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: _____

Submit Completed Form to School Health Office

Original Required

Revised 7/14/2025