



Flushing Community Schools

2026-2027

AUTHORIZATION TO ADMINISTER MEDICATION AT SCHOOL *REQUIRED for ALL Prescription and Non-Prescription Medication*

Student's Name: _____ **Date of Birth:** _____

Teacher: _____ **Grade:** _____
(Elementary Only):

SCHOOL	
ECC	Central
Elms	Seymour
Spvy	
FMS	FHS

To Be Completed by Physician or Authorized Prescriber

Name of Medication: _____

Reason for Medication (Optional): _____

Form of Medication/Treatment: Tablet/Capsule Liquid Inhaler Injections Nebulizer Other

Instructions (frequency/time & dose to be given at school): _____

Start: Date Form Received **Stop:** End of School Year **Or:** For Episodic/Emergency Events Only

Other Dates/Duration: _____

Restrictions and/or important side effects: None Anticipated Yes - If "Yes", please explain:

Special storage requirements: None Refrigerate Other: _____

Please indicate if you have provided additional information: On the back of this form As an attachment

Per administrative discretion, select cases may be reviewed and permission granted to self-administer medication with principal, physician and parent approval and per school policy:	<input type="radio"/> No	<input type="radio"/> Yes (Supervised) <input type="radio"/> Yes (Unsupervised)
This student may carry and is responsible for self-administering an inhaler, per school policy:	<input type="radio"/> No	<input type="radio"/> Yes
This student may carry and has been instructed how to self-administer an epi pen/epinephrine auto injector, per school policy:	<input type="radio"/> No	<input type="radio"/> Yes

Physician's Signature: _____ **Date:** _____

Physician's Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

To Be Completed by Parent/Guardian:

I request that _____ (Name of Child) receive the above medication at school according to standard school policy.

I give permission for exchange of verbal and written communication between the physician and the school nurse and/or designated school staff regarding my child's medication regimen. I request that my child be assisted in taking the medicine(s) described above at school by authorized persons or permitted to medicate herself/himself as also authorized by me and my physician.

Signature: _____ **Date:** _____
(Parent/Guardian)

Home Phone: _____ **Emergency Phone:** _____

