

HEWLETT- WOODMERE PUBLIC SCHOOLS

Parent and Prescriber's Authorization for Administration of Medication in School Authorization for Administration of Medication

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 below, as prescribed by the physician.

Signature (Parent or Guardian): _____

Telephone: Home/Cell _____ Work _____ Date _____

B. To be completed by the licensed health care prescriber:

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

Name of Student: _____ Date of Birth _____

Diagnosis: _____

Name of Medication: _____

Prescribed dosage, frequency and route of administration:

Time to be taken during school hours: _____

Duration or treatment: _____

Possible Side Effects and adverse reactions (if any): _____

Other recommendations: _____

Name of licensed prescriber, title and stamp: _____

Prescriber's Signature: _____ Date: _____

Address: _____ Phone: _____

For Health office use only: Medication is provided and available in the Health Office For epi-pens and
Diphenhydramine only; use nonspecific school supply. RN can only use nonspecific medications.