



West Irondequoit Central School District

321 LIST AVENUE
ROCHESTER, N.Y. 14617
PHONE: (585) 342-5500
FAX: (585) 266-1556
westirondequoit.org

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

Student Name: _____ School: _____

Date of Birth: _____ Grade: _____

A. To be completed by parent or guardian:

I request that my child receive the medication as prescribed below by our licensed health care provider. The medication is to be furnished by me in the properly labeled original container for the pharmacy. I understand that the school nurse or other assigned person will administer the medication. I understand that this must be renewed annually or whenever there is a change in the original prescription.

Signature (Parent or Guardian): _____

Address: _____

Phone- Home: _____ Work: _____ Date: _____

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

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 of Treatment: _____

Possible Side Effects/Adverse Reactions: _____

Other Recommendations: _____

Name of Licensed Prescriber (please print): _____

Address: _____ Phone number: _____

Licensed Prescriber's Signature: _____ Date: _____

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