



Fire Island Union Free School District

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Authorization for Administration of Medication

A. To be completed by 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 will administer the medication or F.I. School District Staff Member, in accordance with Education Law 6908.

Signature (Parent or Guardian): _____ Cell: _____

B. To be completed by 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 of Treatment: _____

Possible Side Effects and Adverse Reactions (if any): _____

Other Recommendations: _____

Name of Licensed Prescriber and Title (Please Print): _____ Stamp: _____

Prescriber's Signature: _____ Date: _____

Address: _____ Phone: _____

C. You have my permission to communicate freely with this health care provider.

Signature (Parent or Guardian): _____