



Holland Patent Central School District

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General William Floyd Elementary: 315.865.5721 **Holland Patent Elementary:** 315.865.8151

Holland Patent Middle School: 315.865.8152

Holland Patent Central High School: 315.865.8154

Date: ____/____/____
MM DD YYYY

Parent/Health Care Provider's Request for Administration of Medication in School-Optional

Student Information:

Last Name:	First Name:	Grade:
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Authorization for the Administration of Medication:

A. To be completed by the parent or guardian annually:

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 from the pharmacy. I understand that the school nurse or other assigned person will administer the medication.

Parent/Guardian Name (please print): _____	Parent/Guardian Signature: _____
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Address: _____

Home Phone: () -	Work/Cell Phone: () -	Date: ____/____/____ MM DD YYYY
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B. To be completed by the licensed health care provider:

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

Name of Student: _____	Date of Birth: ____/____/____ MM DD YYYY
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Diagnosis: _____

Name of Medication(s): _____

Prescribed Dosage, Frequency and Route of Administration: _____

Time to Be Taken During School Hours: _____	Duration of Treatment: _____
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Possible Side Effects and Adverse Reactions (if any): _____

Other Recommendation: _____

Name of Licensed Health Care Provider and Title (please print): _____

Licensed Health Care Provider's Address: _____

Licensed Health Care Provider's Phone: _____

Licensed Health Care Provider's Signature: _____	Date: ____/____/____ MM DD YYYY
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