NORTH MERRICK
UNION FREE SCHOOL DISTRICT
– Nurturing Young Minds –

NORTH MERRICK UNION FREE SCHOOL DISTRICT

NORTH MERRICK, NY 11566

PARENT AND PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

A. To be completed by the parent or guardian:

I request that my child _____, grade/teacher_____, 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, after the school nurse determines my child can take his/her own medication, trained staff may assist my child to take his/her medications in the absence of the school nurse, and on field trips.

Signature (Parent or Guardian):_____

Address:_____

Telephone: Home:_____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 of Treatment:_____

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

Name of Licensed Prescriber and Title (please print): _____

Prescriber's Signature:_____Date: _____

Address: _____

Phone Number:_____