Jericho Union Free School District

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 provider. **The medication is to be furnished by me and brought by me to the Health Office 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.

Signature (Parent or Guardian): _____

Address: _____

Telephone #: _____ 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 and Means of Administering: _____

_____

Time to be Taken During School Hours: _____

Expected Duration of Treatment: _____

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

_____

Other Recommendations (including PRN or self-administration orders): _____

_____

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

Signature: _____ Date: _____

Address: _____ Phone: _____