

# BAY SHORE UNION FREE SCHOOL DISTRICT

## GARDNER MANOR/SOUTH COUNTRY SCHOOL

### HEALTH OFFICE

#### 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 \_\_\_\_\_ in grade \_\_\_\_\_ receive the medication as specified below by my licensed health care provider. The medication is to be furnished by \_\_\_\_\_

Home telephone: \_\_\_\_\_ Work telephone: \_\_\_\_\_ Cell number: \_\_\_\_\_

##### B. TO BE COMPLETED BY THE LICENSED HEALTH CARE PROVIDER:

I request that my patient, as noted below, receive the following medication: (please print)

Name of student: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Name of medication: \_\_\_\_\_

Dosage, frequency and route of administration: \_\_\_\_\_

Time to be taken during school hours: \_\_\_\_\_ Duration of treatment: \_\_\_\_\_

Possible side effects: \_\_\_\_\_

##### LICENSED PRESCRIBER INFORMATION:

Prescriber's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Prescriber's stamp: \_\_\_\_\_

##### SELF-MEDICATION RELEASE FORM

The undersigned child \_\_\_\_\_ in the possession of the above listed medication

We \_\_\_\_\_ and \_\_\_\_\_  
Physician's signature Parent/Guardian signature

Request that \_\_\_\_\_ be permitted to carry the medication on his/her person as we consider him/her responsible. He/She has been instructed in and understands the purpose and appropriate method and frequency of use.