

COLD SPRING HARBOR CENTRAL SCHOOL DISTRICT

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

*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 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 an adult will supervise my child taking his/her own medication.

Signature (Parent or Guardian): \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

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): \_\_\_\_\_

Other Recommendations: \_\_\_\_\_

Name of Licensed Prescriber and Title (please print): \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_