BAY SHORE UNION FREE SCHOOL DISTRICT

GARDINER 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 prescribed below by our licensed health care prescriber. The medication is to be furnished by me in [illegible] the case of the absence of the school nurse, will administer the medication.

Parent/Guardian signature: ______________________ Date: __________

Home telephone: ______________ Work telephone: ______________ Cell number: ______________

B. TO BE COMPLETED BY THE LICENSED HEALTH CARE PRESCRIBER

I request that my patient, as listed 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 above named child has been instructed in the proper use 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 or use.