Jericho
SCHOOL DISTRICT

HEALTH SERVICES

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

A. To be completed by the parent:

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: _____

Home Telephone: _____Mobil:_____

B. To be completed by the licensed health care prescriber:

I request that my patient, as listed below, receive the following medication:

Student:	**DOB:**
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 of Licensed Prescriber (Please Print):_____

Title of Licensed Prescriber _____

Address _____

Phone: _____

Signature of Licensed Prescriber: _____ Date: _____