HUDSON FALLS CENTRAL SCHOOL
HEALTH SERVICES 747-2121 ext. 4218

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

Authorization for Administration of Medication in School

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 in the properly labeled original container from the pharmacy. I understand that the school nurse, or other assigned person will administer the medication.

Signature (Parent or Guardian) : _____

Address: _____

Telephone: Home: _____ Work: _____ Date: _____

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

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

Name of Student: _____ _____ Date of Birth: _____

Diagnosis: _____ ICD-9 Code:_____

Name of Medication: _____

Prescribed Dosage, Frequency and Route of Administration:

_____

Time to Be Taken During School Hours: _____ If AM dose missed at home: _____

Duration of Treatment: _____

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

_____

Other Recommendations (Indications for PRN medications): _____

_____

Name of Licensed Prescriber and Title (please print): _____

License Number of Provider:_____

Prescriber's Signature: _____ Date: _____

Address: _____ Phone: _____