

**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:** \_\_\_\_\_