VALLEY STREAM

UNION FREE SCHOOL DISTRICT THIRTEEN

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

The School Nurse or other designated school personnel (in the absence of the nurse) may cooperate with the family physician and the parents when under certain usual circumstances, a child requires medication during school hours.

The following must be submitted:

1. A written request from the parent.
2. A written order from the family physician stating the name of the child, diagnosis, medication, dosage, frequency and possible side effects.
3. The medication must be properly labeled and taken by the parent to the school nurse.
4. Please fill out the form below and return the entire sheet to the school nurse.

No child should have in his or her possession medication to be taken at school, including over-the-counter medication.

It is extremely important for the school nurse to be informed when a child is on a regular medication in case of any unexpected reaction

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: _____

Medication: _____

Dosage/ Frequency/ Route of Administration: _____

Time to be taken during school hours: _____ Duration of treatment: _____

Possible side effects/adverse reactions: _____

Physician's stamp: _____

Physician's Signature: _____ Date: _____

I do hereby grant permission to school personnel to follow the orders above for medication of my child.

Parent/Guardian's Signature: _____ Date: _____