**CITY SCHOOL DISTRICT OF NEW ROCHELLE**
515 NORTH AVENUE
NEW ROCHELLE, NEW YORK 10801-3416

HEALTH SERVICES DEPARTMENT

TEL: (914)576-4264 FAX: (914)632-3371

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

***Authorization for Administration of Medication*** **SCHOOL: _____**

**A. To be completed by the parent or guardian**: DATE: _____

I request that my child, _____, grade, _____receive the medication as prescribed below by our licensed health care prescriber. 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 _____ Cell _____

**B. 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: _____

Name of Medication: _____

Prescribed Dosage, Frequency and Route of Administration: _____

_____

Time To Be Taken During School Hours: _____

Duration Of Treatment: _____

Possible Side Effects And Adverse Reaction (if any): _____

_____

Other Recommendation: _____

_____

Prescriber's Signature: _____

Prescriber's Name and Title (Please Print):_____ Date: _____

Address: _____ Telephone: _____

**(Name and Address Stamp may be used)**