PLAINVIEW-OLD BETHPAGE SCHOOL DISTRICT,
STRATFORD ROAD SCHOOL

33 BEDFORD AND STRATFORD ROADS
PLAINVIEW, N.Y. 11803

PARENT and PRESCRIBER'S AUTHORIZATION
for
ADMINISTRATION of MEDICATION in SCHOOL

THORIZATION for ADMINISTRATION of MEDICATION

A. *To be completed by the Parent of Guardian:*

I request that my child_____, Grade_____, receive the medication as prescribed below by a 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_____
Home Phone_____ WorkPhone_____ Date_____

3. *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_____
Possible Side Effects and Adverse Reactions (if any)_____
_____
Other Recommendation_____
_____

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

Prescriber's
Signature_____ Date_____
Address_____ Phone_____