PLAINVIEW-OLD BETHPAGE CENTRAL SCHOOL DISTRICT

PARENT AND HEALTHCARE PROVIDER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

A. To be completed by the Parent or Guardian:

I request that my child _____(Date of birth: _____) receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy*. I understand that the school nurse or her designee in the event of her absence will assist the child.

Signature (Parent or Guardian): _____

Telephone: Home _____ Work _____ Date _____

B. To be completed by the Private Healthcare Provider:

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

Name of Student _____DOB _____

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Possible Side Effects and Adverse Reactions (if any):

Prescriber's Signature & Stamp _____ Date:_____

Address: _____ Phone: _____

* *Medication must be in original pharmacy labeled container with specific orders and name of medication.*

* *Medication and refills must be brought to school by parent, guardian or responsible adult.*

This medication order is valid for the current school year and summer school as needed.