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 (DOB):)
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 his/her designee in the event of his/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.