Schoharie Central School District

PO Box 430, 136 Academy Drive, Schoharie, New York 12157

Parent and Prescribers Authorization
Administration of Medication in School

To be completed by parent or guardian

I request that my child____________________________, Grade_______, receive the medication 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 designated person in the case of the absence of the school nurse, will administer the medication.

Signature (Parent or Guardian)____

Address:____

Telephone: Home_______________ Work_______________ Date_______________

To be completed by the licensed health care prescriber

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

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 reactions (if any):___________________________

____

Name of licensed prescriber and title (please print)____________________________

He/She may carry and administer own medication on all field trips? ☐ Yes ☐ No

Prescriber's

Signature:____ Date:______________

Address:____ Phone:_____________