ONONDAGA CENTRAL SCHOOL DISTRICT
PARENT AND PRESCRIBER'S AUTHORIZATION FOR
ADMINISTRATION OF MEDICATION IN SCHOOL

A. To be completed by the parent or guardian:

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 Person in Parental Relation):_____

Address:_____

Phone: Home _____Cell _____ Work _____ Date: _____

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 Reactions (if any):_____

_____

Other Recommendation:_____

_____

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

Prescriber's signature:_____ Date: _____

Address: _____ Phone: _____