



CITY SCHOOL DISTRICT OF NEW ROCHELLE
515 NORTH AVENUE
NEW ROCHELLE, NEW YORK 10801-3416

HEALTH SERVICES DEPARTMENT

TEL: (914)576-4264

FAX: (914)632-3371

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

Authorization for Administration of Medication

SCHOOL: _____

A. To be completed by the parent or guardian:

DATE: _____

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 Guardian) _____

Address: _____

Telephone: Home _____ Work _____ Cell _____

B. To be completed by the licensed health care prescriber:

[Prescribers must be specific concerning dose and frequency. "Per bottle instructions" will not be accepted.]

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 Reaction (if any): _____

Other Recommendation: _____

Prescriber's Signature: _____

Prescriber's Name and Title (Please Print): _____ Date: _____

Address: _____ Telephone: _____

(Name and Address Stamp may be used)