Waterville Central School
Nurse's Office
Fax-315-841-3813

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

A. <u>To be completed by the Licensed Health Care Prescriber</u>

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

Name of Student _____ DOB _____

Diagnosis _____

Name of Medication _____

Prescribed dosage and route of administration _____

Frequency and time to be taken during school hours _____

Duration of treatment _____

For PRN medications – list conditions under which medication should be administered

_____

Name of Licensed Prescriber & Title (please print) _____

Prescriber's signature _____ Date _____

Issuing Physicians Office _____ Phone _____

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B. <u>To be completed by parent or guardian</u>:

I request that my child_____ grade _____, receive the medication as prescribed above 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.

I also hereby request that my child's teacher or other designated faculty member administer the medication on such school-sponsored activities such as field trips, athletic events, etc. during the _____ school year.

The above medication is to be administered during the current school year or until terminated by written notice.

Signature of Parent/Guardian: _____

Address _____

Phone (home) _____ work _____

Date: _____