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:_____