Goshen 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 Guardian) ____

Address: ____

Telephone: Home __________________ 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 ____

____

C. SELF ADMINISTRATION (INHALER & EPI – PEN ONLY)

NO______ YES ______

If YES this medication may be self-administered. The student may carry the medication on their person or keep the medication in their locker. He/she has been instructed in the use of and understands the purpose, frequency and side effects of the medication.

Name of Licensed Prescriber and Title (please print): __________________________
Medical Dr. or Health Care Provider

Signature: ____________________________________ Date: ____________________

Address: _____________________________________ Phone: ___________________