Newburgh Enlarged City School District
Parent and Prescriber‘s Authorization for Administration of Medication in School
School _____

A. To be completed by the parent or guardian:

I request that my child 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 will administer the medication or an adult will supervise my child taking his/her own medication.

Name: _____ Signature: _____
Parent or Guardian (Please print)

Address: _____ Child’s School _____

Telephone: (Home) _____ (Work) _____ (Cell):_____

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 Recommendations: _____

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

Prescriber‘s Signature: _____ Date: _____

Address: _____ Phone: _____

Revised 07/07

Newburgh Enlarged City School District
Parent and Prescriber‘s Authorization for Administration of Medication in School
School _____