

CLARENCE CENTRAL SCHOOLS

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

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 _____

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 Medicine _____

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 _____

