QUOGUE UNION FREE SCHOOL DISTRICT
PO Box 957 – 10 Edgewood Road
Quogue, NY 11959
Telephone (631) 653-4285 / Nurse extension is # 1 Fax (631) 996-4600 / Nurse Fax: (631) 653-4864
PLEASE RETURN FORM TO SCHOOL NURSE

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

In certain circumstances, your licensed health care prescriber may deem it necessary for a student to take medication at school. The New York State Law permits the school to cooperate with the prescriber and the parent in administering medication at school. Before this service may be started, a written request from the parent and a written request from the prescriber, with directions for administering the medication, must be on fie in the office of the school nurse. In compliance with these circumstances, will you please submit the following information:

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 designated person in the case of the absence of the school nurse, will administer the medication. I accept full responsibility for this request and do hereby release school authorities from all responsibility in the administration of the medication.

Signature (Parent or Guardian)_____

Address: _____

Home Phone: _____Work Phone_____Date_____

To be completed by the licensed Health Care Prescriber:

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

Student's Name_____ Date of Birth_____

Diagnosis_____

Name of Medication, Dosage, Frequency and Route of Administration _____

_____

Time to be taken during school _____ Duration of treatment_____

Side Effects and Adverse Reaction (if any) _____

Other Recommendations:_____

Name of Licensed Prescriber & Title (please print)_____

Prescriber's Signature:_____ Date_____

Address_____Phone_____

Health Care Provider's Stamp: