



DR. MICHAEL MUGITS, Superintendent
ERIN L. PETEANI, Principal

171 HUDSON AVENUE, GREEN ISLAND, NEW YORK 12183
Phone: (518) 273-1422
Fax: (518) 270-0818

PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES 2010-11 School Year

A. To be completed by the parent or guardian:

I request that my child _____ DOB _____ receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy*.

Signature (Parent or Guardian): _____
Telephone Home _____ Work _____ Date _____

B. To be completed by physician:

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

Name of Student _____ DOB _____
Diagnosis: _____

Table with 4 columns: MEDICATION, DOSAGE, FREQUENCY/TIME TO BE TAKEN, ROUTE OF ADMINISTRATION

Duration of Treatment:
Possible Side Effects and Adverse Reactions (if any):

PLEASE CHECK ONE:

- I deem this child to be self directed and understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication, including field trips.
I deem this child to be non self-directed and understand that administration of oral, topical, inhalant and injectable medications must remain the responsibility of the school nurse, licensed practical nurse under the direction of a school nurse, physician, or parent.

Physician's Signature _____ Date: _____

Address: _____ Phone: _____

- Medication must be in original pharmacy labeled container with specific orders and name of medication.
Medication and refills must be brought to school by parent, guardian or responsible adult.

Plan reviewed with parent(s)/guardian(s):

Parent Signature: _____ Date: _____