LETCHWORTH CENTRAL SCHOOL

5550 School Road, Gainesville, NY 14066
Phone (585) 493-3520 Fax (585) 493-2536

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

Authorization for Administration of Medication

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 designated person in the case of the absence of the school nurse, will administer the medication.

Signature (Parent or Guardian) _____

Address _____

Phone: Home _____ **Work** _____ **Date** _____

B. To be completed by the licensed health care prescriber: Today's date _____
I request that my patient, as listed below, receive the following medication:

Student Name _____ **Date of Birth** _____

Diagnosis _____

Name of Medication _____

Prescribed Dosage _____ **Frequency** _____

Route of Administration _____

Time to be Taken During School Hours _____

Duration of Treatment _____

Possible Side Effects and Adverse Reactions (if any) _____

_____

Other Recommendations _____

Licensed Prescriber _____ **Date** _____

Prescriber's Signature _____ **Phone** _____

Address _____

DAILY MEDICATION LOG

Student _____ **Date** _____

Grade _____ **Teacher** _____ **Ext #** _____

Parent _____ **Phone** _____

Prescriber _____ **Phone** _____

Medication _____ **Dosage** _____

Frequency _____ **Time** _____

DATE	NURSE	DATE	NURSE	DATE	NURSE	DATE	NURSE	DATE	NURSE	DATE	NURSE

Nurse Signature _____ Initials _____

Nurse Signature _____ Initials _____

Reasons Medication NOT Given
FT – Field Trip NS – No Show
AB – Absent