Newfane Central School District
6273 CHARLOTTEVILLE RD.
NEWFANE, NEW YORK 14108
(716) 778-6888

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION
PRESCRIPTIVE AND OVER THE COUNTER

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 brought to school 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.

Grade: ______________ Teacher: ______________________

Signature (Parent/Guardian) ______________________ Date: __________

Phone (work)______________________ (home)______________________

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______________________ DOB __________

Diagnosis______________________________________

Name of Medication______________________

Dosage/Frequency/Route of administration______________________

Time to be taken during school hours: ______________

Duration of treatment______________________

Possible side effects or adverse reactions______________________

I assess this student to be self-directed ( ) Yes ( ) No
Student may self carry & administer medication ( ) Yes ( ) No

Name & title of licensed prescriber **(Print or Stamp)** ______________________

Prescriber's **signature**______________________ Date__________

Address______________________ Phone__________

****ALL MEDICATION ORDERS EXPIRE AT THE END OF THE SCHOOL YEAR****