Chappaqua Central School District
Post Office 21
Chappaqua, New York 10514

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 container from the pharmacy. I understand that the school nurse or her designee will administer the medication.

Signature (Parent or Guardian):____
Address:____
Telephone: Home____________________work__________________Date:______

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:_________________________Sex:___Date of Birth:__________
Diagnosis:____
Name of Medication:____
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 (please print):__________________________________
Prescriber's
Signature:
_______________________________Date:_________________________
Address:
________________________________Phone:________________________

3/09