Southampton Union Free School District
425 County Road 39A
Southampton, NY 11968

Parent and Prescriber's Authorization For Administration of Medication At School

A. To be completed by Parent or Guardian:

I request that my child_____________________ Grade____receive the medications as prescribed below by my child's Health Care Provider. The medication is to be furnished by me in the properly labeled container from the pharmacy. I give permission for the school nurse to administer the medication or an adult will supervise my child taking his/her own medication:

Signature(Parent or Guardian):____
Address:____
Telephone: Home_______________Cell_________________Work_______________

B: To be completed by Healthcare Provider:

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

Name of Student:_________________________________ 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 or Adverse Reactions (if any):_____________________________
____
Other Recommendations:____

Name of Healthcare Provider and Title (please print):_____________________________

__________________________________ _______________
Prescriber's Signature Date

__________________________________ _________________ ________________
Address Phone Fax