# Manhasset Public Schools

*Health Offices*

## SECONDARY SCHOOL
## Administration of Asthma Medication in School
## Parent and Physician Authorization

**A. TO BE COMPLETED BY THE PARENT OR GUARDIAN:**

I request that my child ___________________________, Grade_____, receive the medication prescribed below by a licensed health care prescriber. The medication is to be furnished by me in a properly labeled, original container from the pharmacy. I understand that the school nurse, or other designated person, in the absence of the school nurse, will administer the medication. Furthermore, I understand that it is my responsibility to notify the school nurse immediately of any changes in the type, dosage or frequency of the medication.

Signature (Parent or Guardian): __________________________________________________

Address: ____________________________________________________________________

Telephone: Home: _______________ Work: _______________________________________

**B. TO BE COMPLETED BY LICENSED HEALTH CARE PRESCRIBER:**

I request that my patient, listed below, receive the following Asthma Medication:

Name: ___________________________ Date of Birth: ________________________________

Diagnosis: ______________________________________________ICD-9 code____________

Prescription directions: _________________________________________________________

Time to be taken:_______________ Duration of Treatment:____________________________

Side Effects/Adverse Reactions:__________________________________________________

**C. SELF-MEDICATION AUTHORIZATION:**

The above named patient has been instructed in the proper use of the following medication procedures:
___________________________________________________________________________

It is requested that ______________________ be permitted to carry the medication on his/her person or to keep the same in his/her locker, as he/she is considered to be responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency for use.

Parent/Guardian Signature: _____________________Physician Signature: _______________

Name & Title of Prescriber (Please print): ________________ Stamp ____________________

Signature: _________________________________Date: ______________________________

Address___________________________________Phone # :___________________________

**Secondary School Health Office:** 200 Memorial Place, Manhasset, NY 11030
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Original Required

Revised 1/7/2020