



# Manhasset Public Schools

Health Office

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

### **A. To Be Completed by The Parent Or Guardian:**

I request that my child \_\_\_\_\_ Grade \_\_\_\_\_ receive the medication as prescribed by 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. Furthermore, I understand it is my responsibility to immediately notify the Health Office of any change in the type, dosage, or frequency of administering the medication. I give my permission to share this information on a need to know basis.

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 medication:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Diagnosis \_\_\_\_\_ ICD-9 code \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Prescribed Dosage, Frequency, and Route of Administration: \_\_\_\_\_

Time to be taken during school hours: \_\_\_\_\_

In the event of a field trip, can this dose be held? Yes \_\_\_\_\_ No \_\_\_\_\_

Duration of Treatment: \_\_\_\_\_

Possible Side Effects and Adverse Reactions (if any): \_\_\_\_\_

Other Recommendations: \_\_\_\_\_

Name of Licensed Prescriber and Title (Please Print): \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Stamp: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Munsey Park School Health Office:** 1 Hunt Lane, Manhasset, NY 11030  
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