Manhasset Public Schools

Health Office

SECONDARY SCHOOL
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:_____

Diagosis_____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:_____

Secondary School Health Office: 200 Memorial Place, Manhasset, NY 11030
Attn: Jill McCarney, RN, MA / Joann Marcucci RN, MS, NCSN
Phone # (516) 267-7520 Fax: (516) 267-7524

REVISED 6/18/2020