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_________________

Epinephrine:____

Dose to be given/Route of Administration:____

Antihistamine:____

Dose to be given/Route of Administration:____

Other (e.g., inhaler-bronchodilator if asthmatic):_____________________________________

Dose to be given/Route of Administration:____

Possible Side Effects and Adverse Reactions (if any):____________________________________

State which of these medications this child can self-administer:___________________________

Name of Licensed Prescriber and Title (Please Print):____________________________________

Prescriber's Signature:______________________Date:____________Stamp:_______________

Address:_________________________________Phone:_______________________________

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