The Greenburgh-Graham UFSD
One South Broadway
Hastings-on-Hudson, NY 10706

PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

A Licensed Health Care Prescriber must complete this form.

Name of Student: _____

Grade: _____ Building: ZIC ES / MS / PBL or MLK HS Date of Birth: ____/____/_____

Diagnosis: _____

Allergies: _____

I request that my patient, as listed above, receive the following prescriptions:

Name of Medication	Dosage	Frequency	Route of Administration	Time Taken at School	Duration of Treatment	Possible Side Effects and/or Adverse Reactions (if any)
1.)						
2.)						
3.)						
4.)						
5.)						

Recommendations: _____

_____

_____

Name of Licensed Prescriber and Title (Please Print)

Address: _____

_____

Phone: (____) _____ - _____ Fax: (____) _____ - _____ Other: (____) _____ - _____

Email: _____@_____.com

_____ _____

Signature *Date*

The Greenburgh-Graham UFSD
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Hastings-on-Hudson, NY 10706

PARENT/GUARDIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

A parent/guardian must complete this form.

Name of Student: _____

Grade: _____ Building: ZIC ES / MS / PBL or MLK HS Date of Birth: ____/____/_____

Name of Parent/Guardian: _____

I request that my child, as listed above, receive the following as prescribed by my licensed health care provider:

Name of Medication	Dosage	Time Taken at School
1.)		
2.)		
3.)		
4.)		
5.)		

The medication is to be furnished by me, in the properly labeled, original container(s) from the pharmacy; plus, an empty, original labeled container to be used for class trips. I understand that the School Nurse or other designated person(s) in case of the absence of the School Nurse will administer the medication(s).

_____ _____

Parent/Guardian Signature *Date*

_____

Name of Licensed Prescriber and Title (Please Print)

Phone: (____) _____ - _____ Fax: (____) _____ - _____ Other: (____) _____ - _____

My child, as listed above, is <u>not</u> currently taking any medication.

_____ _____

Parent/Guardian Signature ***Date***