MT Pleasant Central School District
Thornwood, New York 10594

PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITES
ALL GRADES

A. To be completed by the parent or guardian:

I request that my child ______________________________DOB ____________ receive the medication as prescribed below by our physician. **The medication is to be furnished by me in the properly labeled original container from the pharmacy.**

Signature (Parent or Guardian): ____

Telephone: Home ___________________ **Work** __________________ **Date** ____________

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B. To be completed by physician:

I request that my patient, as named below, receive the following medication:

Name of Student _____________________________________ **DOB** ___________________

Diagnosis: _______________________________**Date**_________________

Medication___________________________________ **Controlled Drug?**_____**Yes**______**No**

Dosage__________________________**Time of Administration**__________________

Begin date_______________ **End date**____________

Specific Instructions____

Possible Side Effects and Adverse Reactions: _____________________________________
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Known Food or Drug Allergies?__________**Yes**___________**No**
If yes, specify____

PLEASE CHECK ONE:

☐ I deem this child can be **SELF-DIRECTED.** I request that the child be permitted to carry his/her medication or keep in locker as we consider him/her responsible. He/she has been instructed in the proper use and understands the purpose and appropriate method and frequency of this medication.

☐ I deem this child to be **non self-directed** and understand that administration of oral, topical, inhalant and injectable medications must remain the responsibility of the school nurse, physician, parent or other trained school designated personnel.

Physician's Signature _________________________________ **Date:** ________________

Address: ____ **Phone:**_____________________