OYSTERPONDS U.F.S.D. IN ORIENT
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ORIENT NY 11957

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AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

To be completed by the parent or guardian:

I request that my child, _____DOB _____ receive the medication as prescribed below by our physician. I understand that the medication is to be furnished by me, must be in original pharmacy labeled container and that medication and refills must be brought to school by parent, guardian or responsible adult.

Signature(Parent or Guardian): _____ Date _____

Telephone: Home _____Work _____Cell _____

To be completed by physician:

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

Name of Student _____DOB _____

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment: _____

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

Physician's Signature _____Date:_____

Address_____Phone:_____

Our mission is to educate and nurture the mind, body and spirit of all students