Pearl River School District

135 West Crooked Hill Road
Pearl River, New York 10965
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PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND AT SCHOOL ACTIVITIES

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:_____

B. 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):

PLEASE CHECK ONE:

☐ I deem this child to be non-self-directed (nurse dependent) and understand that administration of oral, topical, inhalant, and injectable medications must remain the responsibility of the school nurse, licensed practical nurse under the direction of a school nurse, physician, or parent.

☐ I deem this child to be self-directed (needs supervision) and that the school nurse, or other designated person in the case of the absence of the school nurse, will supervise/monitor the administration of medication, including field trips.

☐ I deem this child to self-administer/self-carry (independent) and understand that this privilege may be revoked if the student cannot do so safely.

Physician's Signature: _____ Date: _____

Address: _____Phone: _____

- Medication must be in original pharmacy labeled container with specific orders and name of medication.
- Medication and refills must be brought to school by parent, guardian, or responsible adult.