MEDICATION ORDERS MUST BE RENEWED EVERY YEAR **2016/2017**

HAWTHORNE CEDAR KNOLLS UNION FREE SCHOOL DISTRICT
PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND 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*. I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication, including field trips (in the case of a self directed student).

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 during the school day:

Name of Student _____ DOB _____

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment: 9/01/2016 through 8/31/2017 unless otherwise specified.

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

Physician's Signature _____ Date:_____
Address: _____ Phone:_____

* **Medication must be in original pharmacy labeled container with student name, specific directions and name of medication.**

* Medication and refills must be brought to school by parent, guardian or responsible adult.

Plan reviewed with parent(s)/guardian(s): _____
School Nurse Signature

Revised 07/21/2015ma