YONKERS PUBLIC SCHOOLS

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

A. To be completed by the student's parent or guardian:

I request that my child_____ DOB_____ receive the medication as prescribed below by our licensed health care prescriber. 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.

Signature of Parent/Guardian:_____Date:_____

Address:_____

Telephone: Home:_____Work:_____Cell:_____

B. To be completed by the licensed health care prescriber:

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

Name of Student:_____Date of Birth:_____

Diagnosis:_____

Name of Medication:_____

Prescribed Dosage: Frequency and Route of Administration:_____

_____

Time to be taken during school hours:_____

Duration of Treatment:_____

Possible side effects & adverse reactions (if any):_____

_____

Other Recommendations/activity restrictions (e.g. gym):_____

_____

Patient is self-directed and may self-administer medication YES NO

Prescriber's Signature: _____ **Date:**_____

Address:_____ **Telephone #:**_____

Physician Stamp