Monroe Pediatric Associates, P.C.

A Division of Allied Pediatrics of New York
70 Gilbert Street · Monroe, NY 10950
(845)782-8616

AUTHORIZATION FOR ADMINSTRATION OF MEDICATION IN SCHOOL

A. To be completed by the parent or guardian:

I request that my child _____ grade/HR _____ 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.

I __ do, __ do not want the medication to be given before dismissal on half days.

SIGNATURE (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: _____ DOB: _____

DIAGNOSIS: _____

NAME OF PRESCRIBED MEDICATION: _____

DOSAGE: _____ FREQUENCY: _____ ROUTE: _____

C. Check "Yes" or "No" Below:

NO ___ YES ___ In the event that the a.m. home dose has not been given, the school will contact the parent/guardian for verification. Can the nurse administer this dose?
If yes, the dose to be given is _____

NO ___ YES ___ May this medication be self-administered? Self-administration medication applies only to inhalers, Epi-pens and insulin pumps. If yes, my patient should be Permitted to carry the medication on his/her person, as we consider him/her responsible. He/she has been instructed in the use of, and understands the purpose, frequency, and side effects of this medication.

PRESCRIBER'S NAME: _____ TITLE: _____

PRESCRIBER'S SIGNATURE: _____ DATE: _____

OFFICE STAMP: