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School Nurse Grades UPK- 6th
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School Nurse Grades 7th-12th
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## 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 will be furnished by the parent in the properly labeled original container from the pharmacy, for both prescription and Over the Counter Medication (inc. Tylenol, Benadryl, & Cough Drops) with specific orders Signed by the MD. Unless Self-directed, I understand that the school nurse, or other designated person in the absence of the nurse will administer the medication.

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:

| Medication& Dosage | Time to be taken | Route of administration |
|---|---|---|
| | | |
| | | |
| | | |

Duration of Treatment:______________________________________________________________________

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

Physician's Signature __________________________________Date:_________________________

Address: ____________________________________________Phone:____________________________

Port Byron Central School District has my permission to contact my Child's Doctor and My Child's Doctor has permission to send back needed information and or forms

Doctor's Name_________________________________________Number______________________

Parent's Signature______________________________________Date_______________________