

Bay Shore Union Free School District
Bay Shore High School
55 Third Avenue, Bay Shore, NY 11706
Health Office (631)968-1166 Fax (631)968-2581

SPORT: _____
Parent Sign _____
M D Sign _____

Parent and Prescriber's Authorization for Administration of Medication in School

A. TO BE COMPLETED BY THE PARENT OR GUARDIAN:

I request that my child _____ in grade ____ receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled 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.

Parent/Guardian signature: _____ Date: _____

Address _____

Work Telephone _____

Home telephone _____

B. TO BE COMPLETED BY THE LICENSED HEALTH CARE PRESCRIBER: I

request that my patient, as listed below, receive the following medication (please print all information)

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 and adverse reactions (if any): _____

Other recommendations: _____

NAME OF LICENSED PRESCRIBER AND TITLE (Please Print): _____

Prescriber's Signature: _____ Date: _____

Address: _____ Phone: _____

Physician's Stamp:

SELF-MEDICATION RELEASE

The above named child has been instructed in the proper use of the following medication procedures:

We _____ and _____
Physician's Signature Parent/Guardian Signature

request that _____ be permitted to carry the medication with him/her,

Child's Name

or to keep medication in his/her school or P.E. locker, as we consider him/her responsible. He/She has been instructed in and understands the purpose and appropriate method and frequency of use.