HAUPPAUGE PUBLIC SCHOOLS

PARENT AND PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

A. Must be completed by the parent or guardian:

Authorization for Administration of Prescription and/or Non-Prescription Medication

***Student's Name*_____*Date of Birth*_____**

I request that my child receive the medication as prescribed below by our licensed healthcare provider.

I will furnish medication in the properly labeled original container from the pharmacy, **including OTC medication ie: Tylenol and Ibuprofen.** I understand that medication will not be accepted if it is not provided in the original labeled container, or if it is not being used according to manufacturer's recommendations. I agree to have my child evaluated by my healthcare provider should the school determine my child is requesting a non-prescription medication excessively. My signature below constitutes permission for the school to contact my healthcare provider regarding this form.

Please indicate if your child is self directed in administration and proper use of this medication:

YES:_____ NO:_____

Signature (Parent or Guardian):_____

Telephone: Home/Cell:_____Date:_____

B. Must be completed by the licensed health care provider:

Authorization for Administration of Medication

I request that my patient receive the following medication:

Name of Medication:_____***Dose***_____***Frequency***_____

Route:_____***Side Effects***_____

Diagnosis:_____

Please indicate if patient is self directed in administration and proper use of this medication:

YES:_____NO:_____IF NOT, EXPLAIN_____

*If the usual morning dose given at home has been forgotten, the nurse may administer it at school after verbal or written notification from the parent.

Drug_____AM Dose_____Time_____

Then administer the second dose as follows:_____hours later or no change_____

SIGNATURE OF HEALTHCARE PROVIDER:_____

NAME OF HEALTHCARE PROVIDER:_____

DATE:_____**PHONE:**_____**FAX:**_____

(Please print or stamp)