Middle School Health Office
Fax: (516) 277-7313

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 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, including field trips.

Signature (Parent or Guardian)_____Date_____

Phone # (H)_____(C)_____(W)_____

B. To be completed by physician:

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

Name of Student_____DOB_____

Diagnosis_____

Medication	Dosage	Frequency/Time to be taken	Route of Administration

Duration of Treatment_____

Possible Side Effects and Adverse Reactions (if any)_____

Physician's Signature_____Date_____

*Medication must be in original pharmacy labeled container with specific orders and name of medication. Medication and refills must be brought to school by parent, guardian or responsible adult.

Plan reviewed with parent/guardian_____Date_____

Sea Cliff Health Office
Fax: (516) 277-7509

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 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, including field trips.

Signature (Parent or Guardian)_____Date_____

Phone # (H)_____(C)_____(W)_____

B. To be completed by physician:

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

Name of Student_____DOB_____

Diagnosis_____

Medication	Dosage	Frequency/Time to be taken	Route of Administration

Duration of Treatment_____

Possible Side Effects and Adverse Reactions (if any)_____

Physician's Signature_____Date_____

*Medication must be in original pharmacy labeled container with specific orders and name of medication. Medication and refills must be brought to school by parent, guardian or responsible adult.

Plan reviewed with parent/guardian_____Date_____

Glenwood Landing Health Office
Fax: (516) 676-0972

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 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, including field trips.

Signature (Parent or Guardian)_____Date_____

Phone # (H)_____(C)_____(W)_____

B. To be completed by physician:

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

Name of Student_____DOB_____

Diagnosis_____

Medication	Dosage	Frequency/Time to be taken	Route of Administration

Duration of Treatment_____

Possible Side Effects and Adverse Reactions (if any)_____

Physician's Signature_____Date_____

*Medication must be in original pharmacy labeled container with specific orders and name of medication. Medication and refills must be brought to school by parent, guardian or responsible adult.

Plan reviewed with parent/guardian_____Date_____

Glen Head Health Office
Fax: (516) 277-7712

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 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, including field trips.

Signature (Parent or Guardian)_____Date_____

Phone # (H)_____(C)_____(W)_____

B. To be completed by physician:

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

Name of Student_____DOB_____

Diagnosis_____

Medication	Dosage	Frequency/Time to be taken	Route of Administration

Duration of Treatment_____

Possible Side Effects and Adverse Reactions (if any)_____

Physician's Signature_____Date_____

*Medication must be in original pharmacy labeled container with specific orders and name of medication. Medication and refills must be brought to school by parent, guardian or responsible adult.

Plan reviewed with parent/guardian_____Date_____