

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

*Penfield Central School - Fax: Number*

**A. MUST BE COMPLETED BY THE PARENT OR GUARDIAN:**

I request that my child, \_\_\_\_\_ Grade: \_\_\_\_\_ receive

Drug: \_\_\_\_\_ Dose: \_\_\_\_\_

Reason/symptoms: \_\_\_\_\_ Frequency: \_\_\_\_\_

Permission to carry:  EPI-Pen  Inhaler

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.

Signature (Parent or Guardian): \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Date: \_\_\_\_\_

**B. MUST BE COMPLETED BY THE LICENSED HEALTHCARE PRESCRIBER:**

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

I request that my patient, as listed below, received the following medication:

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Prescribed Dosage, Frequency and Route of Administration: \_\_\_\_\_

Time to be Taken During School Hours: \_\_\_\_\_

Possible Side Effects and Adverse Reactions (if any): \_\_\_\_\_

Other Recommendations: \_\_\_\_\_

Permission to carry:  EPI-Pen  Inhaler

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

Drug: \_\_\_\_\_ AM Dose: \_\_\_\_\_

Then administer the second dose as follows:  \_\_\_\_\_ hours later;  no change

Name of Licensed Prescriber and Title (Please Print): \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**PLEASE SEE REVERSE FOR MEDICATION INFORMATION AND POLICIES**