

**LONG ISLAND LUTHERAN MIDDLE & HIGH SCHOOL
Brookville, New York**

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

To be completed by the parent or guardian:

I request that my child _____, 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 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 _____

To be completed by the licensed health care prescriber:

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

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 (print) _____

Prescriber's Signature _____

Address _____

Phone _____ Date _____