OUR LADY OF VICTORY

Floral Park, New York 11001

PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND AT SCHOOL ACTIVITIES

A. To be completed by the parent or guardian:

I request hereby that my child ____________________________DOB ____________ receive the medication as prescribed below by my physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy*.

Signature (Parent or Guardian): ____

Telephone: Home __________________ Work __________________ Date _____________

B. To be completed by physician:

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

Name of Student:_____________________________ Diagnosis:______________________

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment:____

Possible Side Effects and Adverse Reactions (if any):________________________________

PLEASE CHECK ONE:

☐ I deem this child to be **self-directed** and 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.

☐ I deem this child to be **non self-directed** and understand that administration of oral, topical, inhalant and injectable medications must remain the responsibility of the school nurse, licensed practical nurse under the direction of a school nurse, physician, or parent.

Date:______________ Physician's Stamp:

Signature of Physician:_________________________

Address:_____________________________________

Telephone#___________________________________

* Prescription medication must be in the original pharmacy labeled container.
Medication and refills must be brought to school by parent, guardian or responsible adult.

06/08