Riverhead Central School District

REQUEST FOR ADMINISTRATION OF MEDICATION IN SCHOOL

A. TO BE COMPLETED BY THE PARENT/GUARDIAN:

I request that my child _____ grade _____ receive the medication as prescribed below by our licensed health care provider. 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 absence of the school nurse will assist with the administration of the medication.**

Signature (Parent/Guardian)_____

Address: _____

Telephone #: Home_____ Work_____
Cell_____

B. TO BE COMPLETED BY THE LICENSED PRESCRIBER:

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

Student:_____ Date of Birth:_____

Diagnosis/ICD-9 code:_____

Medication:_____

Dosage/Frequency/Route:_____

_____

Time to be taken during school hours:_____

Duration of treatment:_____

Side Effects/Adverse Reactions/Recommendations:_____

_____

Prescriber's Signature:_____ **Date**:_____

MUST BE AN ORIGINAL SIGNATURE – FAX NOT ACCEPTABLE

Health Care Provider/Title/**License#/NPI# (Please Print or STAMP):**	**PLEASE STAMP IN THIS BOX**
_____ _____ _____ _____ _____	