Goshen Central School District

Parent and Prescriber's Authorization
For Administration of Medication in School

A. 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 assigned person will administer the medication.

Signature (Parent or Guardian) _____

Address: _____

Telephone: Home _____ Work _____ Date_____

B. To be completed by the licensed health care prescriber:

I request that my patient, as listed below, receive 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: _____

Duration of Treatment: _____

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

_____

Other Recommendation _____

_____

C. SELF ADMINISTRATION (INHALER & EPI – PEN ONLY)

NO_____ YES _____ If YES this medication may be self-administered. The student may carry the medication on their person or keep the medication in their locker. He/she has been instructed in the use of and understands the purpose, frequency and side effects of the medication.

Name of Licensed Prescriber and Title (please print): _____

Medical Dr. or Health Care Provider

Signature: _____ Date: _____

Address: _____ Phone: _____