# QUEENSBURY SCHOOL DISTRICT
# PARENT AND PRESCRIBER'S AUTHORIZATION FORM
# ADMINISTRATION OF MEDICATION IN SCHOOL

*Authorization for Administration of Medication*

**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 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. 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 recommendations: _____

_____

Name of licensed prescriber and title (please print): _____

Prescriber's signature: _____ Date: _____

Address: _____ Phone: _____