North Rockland Central School District
65 Chapel Street, Garnerville, New York 10923 Health Services

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

A. To be completed by the parent or guardian:

I request that my child _____DOB _____ receive the medication as prescribed below by our licensed healthcare provider. 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 _____

- **Please note: This information will be shared with School District Staff on a '<u>need to know</u>' basis to safeguard the health of your child.**

B. To be completed by licensed healthcare provider:

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

Name of Student _____ DOB _____

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Possible Side Effects and Adverse Reactions (if any):

Physician's Name (print or stamp) _____
Physician's Signature _____Date_____
Address: _____ Phone:_____

* Medication must be in the original pharmacy labeled container with specific orders and name of medication.
* Medication and refills must be brought to school by a parent, guardian or responsible adult.

This medication order is valid for the current school year and summer school as needed. Any unused medication must be picked up by parents at the end of the school year or medication will be discarded.

PADRE Y AUTORIZACIÓN DEL MÉDICO PARA LA ADMINISTRACIÓN DE MEDICACIÓN EN LA ESCUELA Y LAS ACTIVIDADES ESCOLARES

A. Para ser completado por el padre o tutor:

Solicito que mi hijo(a)_____ Fecha de Naciemiento _____ reciba el medícamento tal como lo prescribe por debajo de nuestro proveedor de cuidado de la salud con licencia. La medicación sera facilitada por mí en el contenedor original debidamente etiquetado desde la farmacia *.

Firma (Padre o Guardian): _____

Teléfono: (Casa)_____ (Empleo)_____ Fecha: _____

- **Favor tome nota: Esta informacion sera compartida con Empleados de Distrito Escolar cuando sea necesario para salvaguardar la salud de su hijo(a).**

B. Para ser completado por el proveedor de atención médica con licencia:

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

Name of Student _____ DOB _____

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Possible Side Effects and Adverse Reactions (if any):

Physician's Name (print or stamp) _____
Physician's Signature _____Date_____
Address: _____ Phone:_____

* Medication must be in original pharmacy labeled container with specific orders and name of medication.
* Medication and refills must be brought to school by parent, guardian or responsible adult.

This medication order is valid for the current school year and summer school as needed. Any unused medication must be picked up by parent at the end of the school year or medication will be discarded.