Byram Hills Central School District
Department of Health Services
School: _____
Telephone: (914) 273 - x 950
Fax: (914) 273 -

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_____ Teacher _____receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy*.

Signature (Parent or Guardian): _____ Date _____

Telephone: Cell _____Home _____ Work _____

B. To be completed by physician:
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

Duration of Treatment: _____

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

Physician's Signature _____Date: _____

Address: _____Phone: _____

SELF-MEDICATION RELEASE: (Epi-pens, Inhalers, etc. as applicable)
Student's Name _____ has been instructed in the proper administration of the following medication and any related procedures: _____
_____

We (Prescriber Signature) _____and Parent /Guardian Signature _____
Request that (Student's Name) _____ be permitted to Carry / Not Carry the above medication as we consider him/her responsible. He/she understands the purpose, appropriate methods of administration, frequency of use and possible side-effects.

* 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.

Plan reviewed with parent(s)/guardian(s):

RN Comments _____

RN Signature: _____ Date: _____