

HEALTH OFFICE
HASTINGS PUBLIC SCHOOLS
HASTINGS-ON-HUDSON, NEW YORK 10706

HILLSIDE
Phone: 478-6280 Fax: 478 3785

FMS/HHS
Phone: 478-6225 Fax 478-6340

**PARENT AND PRESCRIBER'S AUTHORIZATION FOR
ADMINISTRATION OF MEDICATIONS
IN SCHOOL**

Part A. ~ To Be Completed By Parent/Guardian:

I request that my child _____ in 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 will administer the medication. I also understand that on days with delayed openings this medication WILL NOT be administered unless I call that morning to provide information as to when an earlier dose was given.

Signature of Parent/Guardian: _____

Date: _____

Address: _____

Telephone: (home) _____ (work) _____

Part B. ~ To Be Completed By The Licensed Health Care Prescriber:

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

Patient's Name: _____ D.O.B.: _____

Diagnosis: _____

Name of Medication: _____

Prescribed Dosage, Frequency, and Route of Administration: _____

Time(s) to be Taken During School Hours: _____

Duration of Treatment: _____

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

Other Recommendations: _____

Name and Title of Licensed Prescriber (print): _____

Prescriber's Signature: _____ Date: _____

Address: _____ Phone: _____