Greenburgh Central School District
Our Children. Our Focus. Our Future.

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

A. To be completed by parent/guardian:

I request that my child ________________________________ Grade ______ receive the medication as prescribed 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.

Signature Parent/Guardian: ___________________________________ Date: ______________

Home Phone: ___________________________________ Cell Phone: _____________________

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

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

Student Name: _______________________________________ DOB: ____________________

Diagnosis: ____

MEDICATION NAME	DOSE	FREQUENCY	ROUTE	TIME TO BE TAKEN

Duration of Treatment: ____

Possible Side Effects/Adverse Reactions: ____

Other Recommendations: ____

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PLEASE STAMP BELOW

Prescribers Name/Title (Print): ____

Signature: ________________________________
Date: ________________________________
Phone: ________________________________

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