Saint Anthony's High School
275 Wolf Hill Road, South Huntington, New York 11747-1394
631-271-2020 • Fax 631-547-6820 • stanthonyshs.org

Nurse's Office

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

A. To be completed by parent or guardian:

I request that my child _____, grade _____, receive the medication as prescribed below by our licensed health care provider. 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 assigned person, will administer the medication.

Signature (parent or guardian): _____

Telephone: (home/cell) _____ Date: _____

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

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: _____ Route of Administration: _____

Time to be Taken During School Hours: _____ Duration of Treatment: _____

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

Other Recommendations: _____

Name of Licensed Prescriber & Title (please print): _____

Prescriber's Signature: _____ Date: _____

Address: _____ Phone: _____

C. Self-Medication Release:

(Prescriber's signature) _____ and (parent/guardian signature)

_____ request that (child's name) _____

be permitted to carry the medication on his/her person (circle one/both): Epi-pen Inhaler.

He/she has been instructed in and understands the appropriate method and frequency of use.