ROSLYN SCHOOL DISTRICT
ROSLYN, NY

REQUEST FOR ADMINISTRATION OF MEDICATION BY NURSE

Dear Parent:

The State law requires that we have the following information for any student who must take medication during the school day. A new form must be filled out for each medication or medication change and **renewed each school year.**

Student Name:_____ Date of Birth_____ Grade:_____

Home Address:_____ Home Phone:_____

SECTION 1: PHYSICIAN'S ORDERS (To be completed and signed by the healthcare provider)

_____ is to take _____
Name of Student — Medication Name

_____ _____ _____ _____
Duration of Therapy — Dosage — Frequency/Time — Route

_____ _____
Diagnosis — Indications for PRN Use or Scheduled?

_____
Possible Side Effects

_____. _____
Name/Title of Prescriber (Please Print) — Phone

✗_____ _____
Prescriber 's Signature — **Date**

Prescriber's Stamp Required

SECTION 2: PARENTAL CONSENT (To be completed and signed by parent/guardian)

I hereby permit the school nurse or designee to administer the above-prescribed medication according to the above healthcare provider's instructions to my child,_____ during school hours and school-sponsored activities. I understand that I must provide the medication in its original labeled container and will notify the school of any changes. I also release the school and its staff from liability for any adverse effects resulting from this medication.

_____ _____
Parent/Guardian Name (Please Print) — Mobile or Work Phone

✗_____ _____
Signature of Parent/Guardian — **Date**