BREWSTER CENTRAL SCHOOLS

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINES BY SCHOOL PERSONNEL

The New York State Education Department Bureau of Health Services requires a physician's written order and parent or guardian's request for school nurse to administer **any** medication to students.

Please feel free to copy this form if the student requires more than one medication.

To Be Completed by the Physician or Authorized Prescriber

Name of Child__________________________________ Date______________

Reason for Medication____

Name of Medication____

Dosage and Frequency____

Method of Adminstration____

Desired Effects____

Possible Side Effects____

Other Suggestions____

Duration Medication Should Be Administered. From____________________until_______________________

This student is both capable and responsible for self administering this medication (N/A for K-5)

No______ Yes- Supervised _______ Yes- Unsupervised _______

This student may carry this medication. Yes ________ No _______ **(N/A for K-5)**

Signature of Physician ____MD

Stamp:

To be completed by parent/guardian

To___ SCHOOL NURSE ____________________ Date _______________________________________

I hereby request that school personnel give my child ____

the medication ordered above by his/her physician.

Parent/Guardian Signature ________________________________Relationship______________________