Westhill Central School District
School Health Services

PARENT AND PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

A. To be completed by the parent or guardian:

I request that my child_____ 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.

Signature (Parent or Guardian):_____ Date:_____

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

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

Name of student:_____ Date of Birth:_____

Diagnosis:_____ Name of Medication:_____

Prescribed Dosage, Frequency and Route of Administration:_____

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

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

I attest/assess this student to be self directed:
- ❑ Yes
- ❑ No

Student may self carry and self administer:
- ❑ Yes
- ❑ No

Student may self carry, but adult must administer:
- ❑ Yes
- ❑ No

Student is independent with medication administration. The parent/guardian assumes responsibility for ensuring their child is taking the medication as ordered.
- ❑ Yes
- ❑ No

*Note: Nurse will also assess self direction for school setting

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

Prescriber's Signature:_____ Date: _____

Address:_____Phone:_____