

*West Irondequoit Central School District*

**Parent and Prescriber's Authorization for  
Administration of Medication in School**

Student Name: \_\_\_\_\_ School: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

**A. To be completed by the parent or guardian:**

I request that my child 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. I understand that this request must be renewed annually or whenever there is a change in the original prescription.

Signature (Parent or Guardian): \_\_\_\_\_

Address: \_\_\_\_\_

Phone - Home: \_\_\_\_\_ Work \_\_\_\_\_ 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 and Route of Administration: \_\_\_\_\_

\_\_\_\_\_

Time to be Taken During School Hours: \_\_\_\_\_ Duration of Treatment: \_\_\_\_\_

Possible Side Effects / Adverse Reactions: \_\_\_\_\_

Other Recommendations: \_\_\_\_\_

\_\_\_\_\_

Name of Licensed Prescriber (please print): \_\_\_\_\_ Title: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Licensed Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_