Marlboro Central School District

Rosanne Mele
Director of Student Services

PARENT AND PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL, SPORTS & FIELD TRIPS

Authorization for Administration of Medication

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

I request my child _____
Grade _____ DOB_____ 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 designated person in the case of the absence of the school nurse, will administer the medication.

Signature (Parent or Guardian) _____

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

I request that my patient, as listed above, receive the following medication:

Diagnosis: _____

Name of Medication: _____

Prescribed Dosage, Frequency and Route of Administration:

_____

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

_____

Provider's Signature_____ Date_____

Address_____ Phone_____

C. Self Medication Release Option Yes _____ No _____

This student should be permitted to carry the medication on his/her person or PE locker, as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency or use.