# Hamilton Central School


## Health Office

**Phone: 824-6340**
**Fax: 824-6334**


## PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

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

I request that my child ______________________________DOB ____________ receive the medication as prescribed below by our physician. 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, including field trips.

Signature (Parent or Guardian): ____________________________________________________

Telephone: Home ___________________ Work __________________ Date _____________

**B. To be completed by physician:**

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

Name of Student _____________________________________ DOB ____________________

Diagnosis: ____________________________________________________________________

| MEDICATION | DOSAGE | FREQUENCY/TIME TO BE TAKEN | ROUTE OF ADMINISTRATION |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Duration of Treatment:

Possible Side Effects and Adverse Reactions (if any):

Physician's Signature _______________________________ Date:______________________

Address: __________________________________________ Phone:_____________________

* Medication must be in original pharmacy labeled container with specific orders and name of medication.

* Medication and refills must be brought to school by parent, guardian or responsible adult.