

BETHPAGE SCHOOLS
Bethpage, NY

REQUEST FOR ADMINISTRATION OF MEDICATION DURING SCHOOL DAY

Student's Name _____ Telephone _____

Home Address _____ Birthdate _____

School _____ Grade _____ HR _____

Dear Parent or Guardian:

Every effort should be made to administer medication at home, as it represents a disruption in the student's school day. However, if your physician feels that it is necessary, please submit this completed form before medication is sent to school.

A new form must be filled out for each change of medication and renewed each school year. State law does permit administration of medication during the school day only with written directions from the physician and parent. **MEDICATION MUST BE IN THE ORIGINAL PRESCRIPTION BOTTLE.**

Students are at no time allowed to carry medication of any kind (including over the counter) on their person, to take medication without official written directive (from the physician and parent), or to take medication without supervision.

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. I understand that the school nurse will administer the medication.

Signature (Parent or Guardian) _____

Work # _____ Cell # _____

Date _____

B. TO BE COMPLETED BY THE LICENSED HEALTH CARE PERSCRIBER*

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 _____

Possible Side Effects and Adverse Reactions (if any) _____

Name of Licensed Prescriber and Title (print) _____

Prescriber's Signature _____ Date _____

Address _____ Phone _____