



# SPENCERPORT CENTRAL SCHOOL DISTRICT

71 Lyell Avenue  
Spencerport, NY 14559

7513F

## Parent and Prescriber's Authorization to Administer Medication in School

Part 1 below is to be completed by family physician.  
Part 2 is to be completed by parent or guardian.  
Please return by the first day medication is to be given.

### Part 1 (Physician please complete)

\_\_\_\_\_ should receive the medication prescribed by me and described below  
(Name of Child)  
during school hours.

Name of Medication: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_

Dosage: \_\_\_\_\_

Time(s) of administration: \_\_\_\_\_

Time(s) of administration: \_\_\_\_\_

Date to begin medication: \_\_\_\_\_

Date to begin medication: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Physician

### Part 2 (Parent please complete)

I hereby request the medication described above, prescribed for my child be administered by school personnel as ordered.

Child's name: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Relation to child: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

- \* Medication must be in original drug store bottle with specific orders and name of medication.
- \* Medication and refills must be brought to school by parent, guardian or responsible adult.

*Our Mission is to educate and inspire each student to love learning, pursue excellence and use knowledge, skills and attitudes to contribute respectfully and confidently to an ever-changing global community.*