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:

_____

Dosage: _____

Time(s) of administration:

_____

_____

Date to begin medication: _____

Diagnosis: _____

Name of Medication:

_____

Dosage: _____

Time(s) of administration:

_____

_____

Date to begin medication: _____

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.