



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.