Liberty Central School District

2024-25

PARENT AND PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

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 provider. The medication is to be furnished by me in a 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.

Parent/Guardian Signature: _____

Address: _____

Home # _____Work # _____Cell # _____ Date _____

B. To be completed by the licensed health care prescriber:
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 & Route of Administration_____

Time to Be Taken During School Hours_____

Duration of Treatment _____

Possible Side Effects and Adverse Reactions (if any) _____

Other Recommendations _____

Name of Licensed Prescriber and Title (please print) _____

Prescriber _____

Signature _____

Date _____

Address _____ Phone _____