



AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

Ben Porat Yosef will administer OTC or prescription medication provided that we have written authorization from the child's parent/guardian AND the child's doctor. **The medication must be sent to school in the original container with a prescription label** (if applicable).

To be completed by parent/guardian:

Student Name: _____ Grade: _____ Date of Birth: _____

I authorize my child to receive the following medication(s) as directed by our licensed health care prescriber. I understand that the school nurse will administer the medication, or in the case of an emergency, a trained staff member will administer the medication if the nurse is unavailable.

Signature (parent/guardian): _____ Date: _____

To be completed by licensed health care prescriber:

I request that the patient named above receive the following medications as per the following instructions:

*Medication: _____

*Dose/Frequency: _____

*Condition or symptoms medication is being given for:

Special Instructions and or restrictions:

Prescriber's Signature: _____ **Date:** _____

Name of Licensed Prescriber and Title (Stamp or Print): _____

Address: _____

Phone: _____