Our Lady of Mt. Carmel School
Office of the School Nurse
ph: 914-592-7575 x 108 *fax: 914-345-1591*

59 East Main Street
Elmsford, NY 10523

PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

A. To be completed by the parent or guardian:

I request that my child, _____ DOB _____, receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy*.

Signature (Parent or Guardian): _____

Telephone *Home* *Cell* *Work*

B. To be completed by physician:

I request that my patient, as listed below, receive the following medication:

Name of Student: DOB

Diagnosis:

MEDICATION	DOSAGE	FREQUENCY / TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment:

Possible Side Effects and Adverse Reactions (if any):

PLEASE CHECK ONE:

___ I deem this child to be **self-directed** and understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication, including field trips.

___ I deem this child to be **non self-directed** and understand that administration of oral, topical, inhalant and injectable medications must remain the responsibility of the school nurse, licensed practical nurse under the direction of a school nurse, physician, or parent.

Physician's Signature: Date

Address: Phone

* Medication must be in original pharmacy labeled container with specific orders and name of medication.
* Medication and refills must be brought to school by parent, guardian or responsible adult.

Plan reviewed with parent(s) / guardian(s):

Parent Signature: _____ Date _____