



# Bay Shore Union Free School District

Peter V. Di...  
Supervisor of Schools

## BROOK AVENUE SCHOOL

45 Brook Avenue, Bay Shore, New York 11706

Health Office Phone (631) 968-1133 Fax (631) 968-1706

REGINA VORWALD, Principal

CAROL DWORKIN, Assistant Principal

Parent and Prescriber's Authorization for Administration of Medication in Schools

### A. TO BE COMPLETED BY THE PARENT OR GUARDIAN:

I request that my child \_\_\_\_\_ in grade \_\_\_\_\_ receive the medication \_\_\_\_\_

the absence of the school nurse will administer the medication to a designated person in the case of

Address \_\_\_\_\_

Home telephone \_\_\_\_\_

Work Telephone \_\_\_\_\_

### B. TO BE COMPLETED BY THE LICENSED HEALTH CARE PROVIDER:

The following information may be used to determine if the medication is appropriate for use in school (please print all information)

Name of student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Name of Medication: \_\_\_\_\_

Prescribed dosage, frequency, and 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): \_\_\_\_\_

D. \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Physician's Stamp:

### SELF-MEDICATION RELEASE FORM

The above named child has been instructed in the proper use of the following medication \_\_\_\_\_

We \_\_\_\_\_ and \_\_\_\_\_

Physician's Signature