SYOSSET CENTRAL SCHOOL DISTRICT
Syosset, NY

REQUEST FOR ADMINISTRATION OF MEDICATION DURING SCHOOL DAY

Student's Name ____Age______Grade ___________

Home Address ____Phone # __________________

School ____Student ID#_______________

Dear Parent:

In order for any medication, prescription or over-the-counter, to be taken in school, state law requires a written request from a physician indicating the frequency and the dosage of such medication.

The nurse must also have on file a written request from the parent to administer the medication. A new form must be filled out for each change of medication and renewed each school year.

PART I TO BE COMPLETED BY PARENT OR GUARDIAN

I request that the school nurse administer the medication as requested by my physician to my child

____.

I will supply the school nurse with the medication in a container, professionally labeled by the pharmacist; or for an over-the-counter medication; it will be in its original container labeled with the student's name and grade.

____ ____________________________
Signature Relationship

____ ____________________________
Date Work Telephone

PART II TO BE COMPLETED AND SIGNED BY PHYSICIAN

Student't Name ____Date______________________

A. Name of Medication ____

B. Dosage (1) amount to be given ____

(2) time to be given ____

C. Side Effects (1) to report ____

(2) to expect ____

____ ____
Signature of Physician Stamp of Physician

Telephone No. _________________________________