Woodstock Day School

Parent & Prescriber's Authorization for Administration of Medication (During School Hours or School Sponsored Activities)

Authorization for Administration of Medication

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 prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that a school-designated person will administer the medication.

Signature (parent or guardian):_________________________ Date________

B. To be completed by the Licensed Health Care Presciber:

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

Name of student: _______________________________ DOB_________

Diagnosis: ____

Name of medication(s):____

Prescribed dose & means of administration: __________________________

____

Time medication should be taken: __________________________________

Expected duration of treatment: ____________________________________

Possible side effects & adverse reactions (if any): ______________________

____

Other recommendations (including PRN or self-administration orders):____

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Name/Title of Licensed Prescriber (Please Print):______________________

Signature_______________________________________ Date____________

Address:____________________________________ Tel. Number:_________