BELLMORE-MERRICK C.H.S.D ATHLETIC OFFICE
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PARENT AND PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL/FIELD TRIPS

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 the school nurse or other designated person, in the case of the absence of the school nurse, will administer the medication unless the student is able to self-administer with Doctor's order.

Signature (Parent or Guardian): ____Date :______________________

Home Tel #:___________________________ Work Tel #:_________________________ Cell#:___________________

B. To be completed by the licensed health care prescriber:
I request that my patient, as listed below, receive the following medication:

Name of Student : ____Date of Birth :___________________________

Diagnosis: ____

Name of Medication:____

Prescribed Dosage and Means of Administering:____

____

Time to be Taken/Time in between doses: ____

Possible Side Effects and Adverse Reactions (if any):____

Name and Title of Licensed Prescriber (print): ____

Doctor's Stamp

Doctor's Signature:_____________________________________

Address:____

Phone: ____

***Please note: self-carry/self-administration forms must be completed separately**