MINISINK VALLEY CENTRAL SCHOOL DISTRICT
Office of the School Nurse
PO Box 217, Slate Hill, NY 10973

Daily Medication Log

Authorization for Administration of Medication

TO BE COMPLETED BY 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 absence of the school nurse, will administer the medication.

Signature Parent/Guardian: _____ Date: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Number: _____

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, 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): _____

Prescriber's Signature: _____ Date: _____

Address: _____ Phone: _____