



WEST ISLIP PUBLIC SCHOOLS

School Health Services

PARENT AND HEALTHCARE PROVIDER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

A. To be completed by the parent or guardian:

I request that my child _____ DOB _____
receive the medication as prescribed below by our physician. The medication is to be
furnished by me in the properly labeled original container from the pharmacy.*

Parent Signature _____ Date _____

B. To be completed by the Private Healthcare Provider:

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

Student's Name _____ DOB _____

Diagnosis _____

Medication _____

Dosage _____ Route _____ Frequency _____

Time to be taken during school hours _____

Possible side effects or adverse reactions (if any):

Health Care Provider's
signature: _____ Date _____

Physician Information: (Please Stamp)

This medication order is valid for the current school year and summer school as needed.

*Medication must be in original pharmacy labeled container with specific orders and name of medication.

*Medication and refills must be brought to school by parent, guardian or responsible adult.