Oyster Bay-East Norwich Central School District

Authorization for Administration of Medication in School

A. TO BE COMPLETED BY THE PARENT/GUARDIAN

I Request that my child ______________________________ Grade __________ receive the medication as prescribed below by our licensed health care provider. 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 absence of the school nurse, will administer the medication.

Signature of Parent/Guardian ____________________________________Date__________
Address ____
Home Phone ________________________________ Cell ______________________________

B. TO BE COMPLETED BY LICENSED MEDICAL CARE PRESCRIBER

I request that my patient, as listed below received the following medication:
Student Name ____DOB ________________
Diagnosis ____
Name of Medication ____
Dose/Frequency/Route ____
Time of administration ______________________Duration of Treatment________________
Possible Side Effect/Adverse Reactions____
____
OtherRecommendations/Considerations____
____

Name and Title of Practitioner ____

Address ____Phone ________________

Signature ____Date ________________

High School Nurse – 516-624-6541
Fax – 516-624-7314

Vernon Nurse – 516-624-6565
Fax – 516-624-2024

Roosevelt Nurse – 516-624-6575
Fax – 516-624-6591

TYLENOL AND/OR ADVIL PERMISSION SLIP

NEW YORK STATE EDUCATION DEPARTMENT REQUIRES THAT ALL MEDICATION, INCLUDING NONPRESCRIPTION DRUGS, GIVEN IN SCHOOL BE PRESCRIBED BY A LICENSED PRESCRIBER.

Name of Student ______________________________DOB ________

OBHS ______ Vernon_______ Roosevelt _______ Grade ____________

Medication Allergies: ______________________________________

Daily Medications: ____

Acetaminophen (Tylenol) and/or Ibuprofen (Advil) may be given to students who have a written order from a licensed prescriber and written parental permission. Acetaminophen may be administered every 4 to 6 hours: Ibuprofen may be administered every 6 hours.

I give permission for the school nurse to administer:

Acetaminophen (Tylenol) 325-650mg p.o. and/or Ibuprofen (Advil) 200-400 p.o.

to my child as needed. No Allergy to this medication is presently known. I will notify the school nurse if at any time in the future my child should not receive this medication.

This permission will be in effect until the end of this school year

Parent/Guardian Signature ______________________________Date ________

Prescriber Signature ______________________________Date________

MUST BE SIGNED BY A PHYSICIAN

DATE	TIME	MEDICATION	SIGNATURE	REASON