

**KEENE CENTRAL SCHOOL**

33 Market St., P.O. Box 67, Keene Valley, NY 12943  
(518) 576-4555 Fax (518) 576-4599 [www.keenecentralschool.org](http://www.keenecentralschool.org)

**AUTHORIZATION FOR ADMINISTRATION OF MEDICATION:**

**A. TO BE COMPLETED BY THE PARENT OR GUARDIAN:**

I request that my child \_\_\_\_\_ in grade \_\_\_\_ receive the medication as prescribed 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 case of absence of the school nurse, will administer the medication.

Signature (parent or guardian) \_\_\_\_\_

Address \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Date \_\_\_\_\_

**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, 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: \_\_\_\_\_

