ST. JOHN THE BAPTIST DIOCESAN HIGH SCHOOL

1170 Montauk Highway • West Islip, New York 11795-4959

(631) 587-8000 Fax (631) 587-8996

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 _____Grade__ 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: (**MUST HAVE MD 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.
ALL MEDICATIN MUST BE PICKED UP IN JUNE> NO MEDICATION CAN BE STORED OVER THE SUMMER.