

THE PORT BYRON CENTRAL SCHOOL DISTRICT

School Nurse Grades Upre K- 6th
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School Nurse Grades 7th-12th
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**PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF
MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES**

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 will be furnished by the parent in the properly labeled original container from the pharmacy, for both prescription and Over the Counter Medication (ie Tylenol, Benadryl, & Cough Drops) with specific orders Signed by the MD. Unless Self-directed, I understand that the school nurse, or other designated person in the absence of the nurse will administer the medication.

Signature(Parent or Guardian): _____

Telephone: Home _____ Work _____ Date _____

B. To be completed by Physician:

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

Name of Student _____ DOB _____

Diagnosis: _____

MEDICATION& Dosage	TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment: _____

Possible Side Effects and Adverse Reactions (if any): _____

Physician's Signature _____ Date: _____

Address: _____ Phone: _____

Port Byron Central School District has my permission to contact my Child's Doctor:

Doctor's Name _____ Number _____

Parent's Signature _____ Date _____