The WALDORF SCHOOL of GARDEN CITY

PARENT AND PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

This section to be completed by a parent or guardian:

I request that my child 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 will administer the medication (or in her absence, a designated adult will supervise my child taking his/her own medication).

Student's Name:		DOB:	Grade:
Parent's or Guardian's Name:			
Address:			
Telephone Home:	Cell:	Work:	
Signature of Parent or Guardian:			Date:

This section to be completed by the licensed health care provider:

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

Student's Name:	
Diagnosis:	
Medication, Dosage and Route:	
Frequency / Time to be taken during school hours:	
Duration of Treatment:	
Possible Side Effects:	
Name of Licensed Healthcare Prescriber & Title:	
Prescriber's Signature and Date:	
Address:	
Telephone Number:	