



**La Salle Institute**

174 Williams Road – Troy, NY 12180 – (518)283-2500 – [www.lasalleinstitute.org](http://www.lasalleinstitute.org)

**ADMINISTRATION OF PRESCRIPTION MEDICATION IN SCHOOL**

**A. AUTHORIZATION BY PARENT OR GUARDIAN**

I hereby request that my son \_\_\_\_\_, grade \_\_\_\_\_, receive the medication as prescribed below by our licensed health care prescriber. 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 her absence, will administer the medication.

Date: \_\_\_\_\_  
Signature of Parent or Guardian

Telephone numbers: Home \_\_\_\_\_ Work: \_\_\_\_\_

**B. AUTHORIZATION OF PHYSICIAN**

I request that my patient 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: \_\_\_\_\_

Any other recommendations: \_\_\_\_\_

Name of licensed prescriber and title (please print or use stamp):  
\_\_\_\_\_

Address of medical office: \_\_\_\_\_

Telephone number: \_\_\_\_\_

Date: \_\_\_\_\_ Signature of prescriber: \_\_\_\_\_