La Salle Institute
174 Williams Road – Troy, NY 12180 – (518)283-2500 – www.lasalleinstitute.org

ADMINISTRATION OF PERSCRIPTION 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 _____

Diagonis:_____

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:_____