

**CapitalCare Pediatrics Albany**

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**Patient and Prescriber's Authorization For  
Administration of Medication in School**

*Authorization for Administration of Medication*

**A. To be completed by the parent or guardian:**

I request that my child \_\_\_\_\_ receive 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 the case of the absence of the school nurse, will administer the medication.

Signature (Parent or Guardian) \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Date \_\_\_\_\_

**B. To be completed by the licensed health care prescriber:**

I request that my patient, as 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): \_\_\_\_\_

Other Recommendations: \_\_\_\_\_

Prescriber's  
Signature \_\_\_\_\_ Date: \_\_\_\_\_