Capital*Care* 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:_____

_____

Prescriberôs
Signature_____Date:_____