York Preparatory School

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New York, NY 10023-6092
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www.yorkprep.org

Dear Parents:

According to the medical forms submitted for your child, there is an indication that he/she has ______________________. Based on this information we request that you provide the school with any appropriate prescription medication for your child. We will need you and your physician to fill out the below information regarding any medication the child will need to take at school. If the medication is over the counter, please provide the name as well as specifications for dosage and use. All medications can be delivered to the attention of the school nurse at York Prep.

Thank you for your cooperation and assistance in ensuring the best possible care for your child.

Authorization for Administration of Medication

A. To be completed by the parent or guardian:

I request that my child _______________________ 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 will administer the medication or an adult will supervise my child taking his/her own 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: ____

Name of Licensed Prescriber and Title (please print): ____

Prescriber's Signature: ______________________________________ Date: _______________________

Address: ____ Phone: ____