CAIRO-DURHAM CENTRAL SCHOOL DISTRICT

PARENT AND PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL
2014-2015 School Year

Name of School: (Please (√) one box)

( ) Cairo-Durham Elementary School ( ) Cairo-Durham Middle School ( ) Cairo-Durham High School

To be completed by parent or guardian:

I request that my child _____ grade _____ receive the medication as prescribed below by our licensed health care prescriber. The medication will 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 of Parent/Guardian Date

Telephone: Home _____ Work _____ Cell _____

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 _____

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 Recommendation _____

_____
Name of Licensed Prescriber and Title (Please Print)

_____ _____
Signature of Prescriber Date

Revised: 3-3-15