PORT WASHINGTON PUBLIC SCHOOLS
PORT WASHINGTON, NEW YORK 11050

PARENT AND PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

Use only one form for each medication prescribed.

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, or other designated person in the case of the absence of the school nurse, will administer the medication.

Signature (Parent or Guardian): ____________________________________ Date: ________________

Telephone: Home __________________ Work __________________ Allergies: ____________________

I understand that the nurse will notify all appropriate staff of my child's allergies. I am aware that this open communication is necessary in protecting my child from a potentially serious, life-threatening allergic reaction. I will inform the nurse of any changes in my child's status, i.e.: new allergies.

B. Self-medication release form (For Inhaler or Epi-Pen Only)

Above student is permitted to carry the medication on his/her person, as we consider him/her responsible. He/she has been instructed in and understands the purpose, appropriate method and frequency of use.

Physician's signature ____

Parent or Guardian's signature ____

C. 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: ____

Dosage: ________________ **Frequency:** ____________________ **Route of Administration:** ________________

Possible Side Effects and Adverse Reactions (if any): ______________________________________

Other Recommendations: ____

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

Prescriber's Signature: __________________________________ Date: _________________________

Address: ________________________________ Phone: ___________________________________

SCHOOL HEALTH SERVICES
DAILY MEDICATION SHEET FOR 2021-2022 SCHOOL YEAR

Name: ______________________ Doctor: ______________________ Date: ____________

Medication: ______________________ Dose: ______________________ Time: ____________

SEPTEMBER

Week	Date	M	T	W	TH	F
1	9/1-3					
2	9/6-10					
3	9/13-17					
4	9/20-24					
5	9/27-30					

OCTOBER

Week	Date	M	T	W	TH	F
1	10/1					
2	10/4-8					
3	10/11-15					
4	10/18-22					
5	10/25-29					

NOVEMBER

Week	Date	M	T	W	TH	F
1	11/1-5					
2	11/8-12					
3	11/15-19					
4	11/22-26					
5	11/29-30					

DECEMBER

Week	Date	M	T	W	TH	F
1	12/1-3					
2	12/6-10					
3	12/13-17					
4	12/20-24					
5	12/27-31					

JANUARY

Week	Date	M	T	W	TH	F
1	1/3-7					
2	1/10-14					
3	1/17-21					
4	1/24-28					
5	1/31					

FEBRUARY

Week	Date	M	T	W	TH	F
1	2/1-4					
2	2/7-11					
3	2/14-18					
4	2/21-25					
5	2/28					

MARCH

Week	Date	M	T	W	TH	F
1	3/1-4					
2	3/7-11					
3	3/14-18					
4	3/21-25					
5	3/28-31					

APRIL

Week	Date	M	T	W	TH	F
1	4/1					
2	4/4-8					
3	4/11-15					
4	4/18-22					
5	4/25-29					

MAY

Week	Date	M	T	W	TH	F
1	5/2-6					
2	5/9-13					
3	5/16-20					
4	5/23-27					
5	5/30-31					

JUNE

Week	Date	M	T	W	TH	F
1	6/1-3					
2	6/6-10					
3	6/13-17					
4	6/20-24					
5						

COMMENTS

NURSE'S SIGNATURE	INITIAL	DATE